EAST CHESHIRE NHS TRUST

Pressure Injury Prevention and

Treatment Policy
Policy: Pressure Ulcer Prevention and Treatment Policy

Executive Summary: This policy for the prevention and treatment of pressure injury is for East Cheshire Trust. The aim is that there will be no avoidable pressure injury developing within the Trust (DOH high impact actions 2009).

This policy covers details on risk assessment, appropriate intervention for prevention and treatment of pressure injury, documentation and staging of pressure injury.

Supersedes: Pressure Ulcer Prevention guidelines 2014 now out of date

Description of Amendment(s): Rewritten

This policy will impact on: All Trust Staff

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1. Introduction
This policy is for the prevention and treatment of pressure injury for East Cheshire Trust. The aim is “there will be no avoidable pressure injury developing within the Trust” (DoH high impact actions 2009). Pressure injury is often preventable and their prevention is included in domain 5 of the Department of Health’s NHS outcomes framework 2014/15 (NICE CG 179 2014).

The guidance for Pressure injury prevention is provided nationally, within the National Institute for Clinical Excellence (NICE) (2014) Clinical Guideline 179 and NICE quality standard 89 (2015)

Pressure injury should not be seen as an inevitable consequence of ill Health or Hospitalisation

2. Objectives of Policy
The purpose of this policy is to ensure best practice following national guidance and minimise the potential of inconsistency of care through standardising approaches to pressure injury prevention and management and care by:

- Preventing the development of pressure injury where ever possible and implementing individualised treatment plans to effectively manage existing pressure injury
- Standardising the assessment and management of individuals who are at risk of developing pressure damage or who have existing pressure damage
- Supporting families, carers and healthcare professionals with a framework for the prevention and management of pressure injury.

3. Roles and responsibilities
3.1 The Director of Nursing, Performance and Quality:
- On behalf of the Chief Executive, will ensure that comprehensive guidance for pressure injury prevention and management within the Trusts are developed, agreed and reviewed
- Will ensure that resources are made available for the provision of appropriate pressure relieving equipment
- Will ensure that there is a rolling programme for foam mattress replacement following the annual audit of foam mattresses
- Will ensure that there is a robust monitoring system in place for the measurement of incidence of pressure injury
- Will ensure that there are robust systems in place for reporting developed stage 3 & 4 pressure injury as serious incidents

3.2 Lead Nurses/Professional Leads/Business Unit Service Managers:
- Will ensure that this policy is implemented within their area of responsibility
- Will ensure that all stage 3 &4 pressure damage that develops within their area has a route cause analysis (RCA) undertaken and that action plans are put in place to improve patient care

3.3 Hospital Matrons:
- Will ensure that all staff in their areas are aware of, understand the policy and will ensure compliance with the policy
- Will ensure monitoring processes are in place to give confidence that this policy is being followed
Will ensure that any actions related to clinical areas in relation to pressure Injury prevention and treatment are put in place

3.4 Head of Safety Risk and Resilience:
Is responsible for;
- Ensuring Datix incident reporting system is in place.
- Providing trend analysis and assurance reports in relation to improvement action and learning in line with trust as a result of incidents reported.
- Reporting to the CCG’s and the Strategic Executive Intelligence System (StEIS) all stage 3 and 4 pressure damage following confirmation of the stage of the pressure Injury by the Tissue Viability Team and approval by the Executive team
- Reporting to the CCG’s pressure injury admitted to hospital where other agencies have been involved.

3.5 Ward/Department/ Managers/ District Nurse Leads/ Community Matrons
- Will ensure that all staff are aware of the policy and adhere to it
- Will identify training needs and ensure staff are appropriately trained in pressure injury prevention and management and will record all training
- Will incorporate pressure injury prevention and management into staff performance review and the Knowledge and Skills framework
- Will use the available resource to ensure patients are provided with the correct pressure reducing/relieving equipment
- Will ensure that the Matron/Professional leads responsible for the clinical area are aware of all incidents/ failures to comply with the policy.

3.6 All Staff
- Will adhere to the policy
- Will use the information provided at a clinical level to ensure correct choice of pressure reducing/relieving equipment and use this in a safe manner assessing risk as part of patient care.
- Will identify their training needs and make their managers aware of any training deficit. It is an individuals responsibility to maintain personal records of all training
- Will complete any mandatory training in relation to pressure injury prevention and management
- Will report all stage 2 and above incidents including unstageable pressure damage via the ECT incident reporting system (Datix)
- Will refer all stage 3, 4 unstagable pressure damage and all deteriorating wounds to the Tissue Viability Team
- Will report stage 3 or 4 pressure damage via the Vulnerable Adults trigger form following the safeguarding protocol if deemed appropriate.

3.7 Tissue Viability Nurse
The Tissue Viability Nurse will be responsible for;
- Monitoring of pressure injury prevalence and liaising with other members of the Trust to ensure clinical practice is developed in line with evidence and best practice.
- Identifying to the line manager when the practice is not compliant with best practice/guidance
- To deliver training on the prevention and management of pressure injury as identified through personal development plans
- Reviewing the Pressure Injury Prevention and Treatment Policy on a two yearly basis
- Assessing all patients with a stage 3 or 4 and unstageable pressure Injury and deteriorating wounds and notifying risk through the incident management system verification of staging
- Assist in the Route cause analysis process to identify areas of practice that do not meet best practice/guidance.
4. Definitions

4.1 Pressure Injury
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open injury and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (NPUAP April 2016).

4.2 Staging of Pressure Injury
See section 6 page 13 following NPUAP classification system

4.3 Avoidable Pressure Injury
“Avoidable” means that the person receiving care developed a pressure injury and the provider of care did not do one of the following: evaluate the person’s clinical condition and pressure injury risk factors; plan and implement interventions that are consistent with the person’s needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.”

4.4 Unavoidable Pressure Injury:
“Unavoidable” means that the person receiving care developed pressure damage even though the provider of the care had evaluated the person’s clinical condition and pressure injury risk factors; planned and implemented interventions that are consistent with the person’s needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence”

4.5 “On District Nurse caseload”
This is defined for incident reporting purposes for pressure damage as “seen within 4 weeks”. Any patients that have regular reviews but are seen less frequently than every 4 weeks and develop a pressure injury are classed as having a pressure injury that is “admitted to caseload”.

4.6 Pressure Ulcer Incidence
Incidence is defined as the number of persons who develop a new pressure injury, within a particular time period in a particular population. (Oxford Dictionary 2009)

Other ECT documents to be read in conjunction with this procedure
Wound Management Guidelines
SOP Topical Negative Pressure
5. Assessment

5.1 Clinical Assessment

Initial Adult Pressure Injury Assessment Flow Chart – A & E through to and including admission

Adult patient admitted to the Emergency Department majors or resus

Emergency Department pressure prevention risk assessment tool completed which includes skin inspection within 2 hours

Patient not identified at risk of developing a pressure injury (using screening assessment)

Patient identified at risk of developing a pressure injury (Using screening assessment) commence repositioning chart. If unable to reposition on trolley transfer onto a bed

Patient identified as having existing pressure damage or has dynamic equipment at home, commence repositioning chart and consider moving patient to a bed with a dynamic mattress (dependant on reason for A/E admission)

Patient admitted to in-patient area, a skin inspection and Waterlow risk assessment to be undertaken and recorded in the nursing documentation by a registered practitioner within six hours of admission

Patient provided with written and verbal pressure prevention information if at risk of developing damage

Patient not identified at risk of developing a pressure injury on admission

- Undertake nutritional assessment
- Weekly reassessment of risk or more frequently if condition changes

Patient identified at risk of developing a pressure injury on admission but no pressure injury

- Commence repositioning chart – identify frequency required dependant on risk
- Undertake nutritional assessment
- Weekly pressure risk assessment or more frequently if condition changes
- Consider use of dynamic mattress if patient unable to reposition

Patient identified as having a stage 1, 2 pressure injury or deep tissue injury on admission

- Commence repositioning chart - identify frequency dependant on risk
- Undertake nutritional assessment
- Commence wound management plan if skin broken
- Weekly risk assessment or more frequently if condition changes
- Consider use of dynamic mattress if patient unable to reposition
- Complete incident report form if skin broken due to pressure

Patient identified as having a stage 3, 4 or unstageable pressure injury on admission

- Commence repositioning chart
- Undertake nutritional assessment
- Commence wound management plan
- Ensure patient placed on appropriate alternating mattress
- Weekly risk assessment or more frequently if condition changes
- Complete incident report form
- Refer to Tissue Viability Nursing Service
- Consider safeguarding
5.2 Risk Assessment in A/E
All patients who enter A & E will be screened for the likelihood of them developing a pressure Injury. This will be determined using a local screening tool.

Once screened, if the patient is deemed to be at risk of developing pressure injury pressure ulcer prevention strategies will be undertaken – taking into account the patients reason for admission.

If the patient is found to be at risk:
- Preventative measures will be instigated and recorded.
- The patient will be fast tracked through the department as quickly as their condition allows. If the patient is to be admitted the bed manager will be made aware of the patient’s level of risk so that the appropriate pressure-relieving equipment can be secured.

Documentation of this screening and assessment is recorded within the A/E documentation. Waterlow risk assessment will be undertaken within 6 hours of admission.
5.3 In-Patient Initial Clinical Assessment

Chart 2 - On-going In-patient Pressure Injury Assessment Flow Chart

Patients Waterlow Risk assessment reassessed weekly or more frequently if patients condition changes

Patient not identified at risk of developing a pressure injury
- Undertake nutritional assessment
- Weekly reassessment of pressure risk assessment or more frequently if condition changes

Patient identified at risk of developing a pressure injury during their admission (no actual injury)
- Commence repositioning chart – identify frequency dependant on risk
- Undertake nutritional assessment
- Pressure injury assessment Weekly or more frequently if condition changes
- Consider use of dynamic mattress if patient unable to reposition

Patient develops a stage 1, 2 pressure injury or deep tissue injury during their admission
- Commence repositioning chart – identify frequency dependant on risk
- Undertake nutritional assessment
- Commence wound management plan if skin broken
- Weekly risk assessment or more frequently if condition changes
- Consider use of dynamic mattress if patient unable to reposition
- Complete incident report form (datix) if skin broken due to pressure

Patient develops a stage 3, 4 or unstageable pressure injury during their admission
- Commence repositioning chart – identify frequency dependant on risk
- Undertake nutritional assessment
- Commence wound management plan
- Ensure patient placed on appropriate dynamic mattress
- Weekly risk assessment or more frequently if condition changes
- Complete incident report form
- Refer to Tissue Viability Nursing Service
- Consider safeguarding (Appendix 8)

If the patient is transferred to another area during their admission
- A skin inspection and Risk assessment review must be completed prior to transfer
- A skin inspection and Risk assessment review must be completed following transfer

In-Patient Initial Clinical Assessment
All patients must receive a pressure Injury risk assessment using; the Waterlow Risk assessment tool for general nursing (age 18 and upwards), http://www.jud-waterlow.co.uk/waterlowscore.htm
- Maternity Risk Assessment tool for Maternity Appendix 1
- Braden Q tool for Paediatrics and Neonates (0-18). Appendix 2
This assessment is to be completed within six hours of admission as part of the holistic initial assessment and documented in the nursing record. The pressure injury risk assessment must be undertaken by a registered healthcare professional that is trained and competent in this assessment.

**In-patient on-going Clinical Assessment**
Reassessment of risk should be at least weekly or more frequently if patient’s condition deteriorates. This would include if the patient was going to theatre or bed rest/ restricted mobility was being enforced for any reason. Patients should have a risk assessment and skin reassessment when leaving a clinical area and when arriving at a new area e.g. transfer to another ward.

**5.4 Community Initial Clinical Assessment**
All patients must receive a pressure injury risk assessment using:
- the Waterlow Risk assessment tool for general nursing,
- the Braden Q tool for paediatrics.

All patients under the care of ECT must have an initial pressure injury risk assessment undertaken on first Episode of care. Within ECT “Special schools” this will be done on first assessment to the school.

**Community on-going clinical assessment**
Patients on the community should have the frequency of reassessment clearly identified in the nursing record. This should be based on the patient’s risk level of developing pressure injury. This should be a minimum of 3 monthly (with the exception of Special Schools) or more frequently if patient’s condition deteriorates. For children in “Special Schools” the Risk assessment will be undertaken annually or more frequently if condition deteriorates.

**6. Pressure Injury Prevention**

**6.1 Skin Assessment**

**Potential areas for pressure damage**

The areas on the skin that are vulnerable to pressure are:
Special attention also needs to be given to ears, noses and mouths due to any invasive tubes routinely used.

Consider frequency of skin inspection if patient is at high risk of developing pressure injury and is placed in a cast. Record any risk assessments associated with this.

Full skin inspection is to be done on admission – this means removing all existing dressings and bandaging that the patient came in with (INCLUDING COMPRESSION BANDAGING).

Any device on the skin that can be removed safely is to be removed at least each shift /visit to inspect the skin for any pressure damage and the results of the inspection recorded.

**Pressure identification using the staging system**

Pressure injuries are staged to indicate the extent of tissue damage. The stages were revised based on questions received by NPUAP from clinicians attempting to diagnose and identify the stage of pressure injuries (NPUAP April 2016).

**Stage 1 Pressure Injury: Non-blanchable erythema of intact skin**

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Colour changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

**Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis**

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSII), or traumatic wounds (skin tears, burns, abrasions).

**Stage 3 Pressure Injury: Full-thickness skin loss**

Full-thickness loss of skin, in which adipose (fat) is visible in the injury and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunnelling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the Injury. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunnelling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the Injury cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Additional pressure injury definitions.

Medical Device Related Pressure Injury:
This describes an etiology.
Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

Mucosal Membrane Pressure Injury: Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged.

Pressure injury cannot be reverse staged as they start to heal.

Moisture lesions
There is often confusion between a pressure injury and a lesion that is caused by the presence of moisture, for instance because of incontinence or perspiration. The differentiation between the two is of clinical importance since prevention and treatment strategies differ greatly. See Appendix 3 for the different characteristics of pressure injury and moisture lesions.

6.2 Surface

Pressure Relieving Equipment
Assessment
Once the level of risk is identified, pressure-relieving devices should be chosen on the basis of:
- Risk assessment
- Pressure Injury assessment (severity) if present
- Location and cause of pressure Injury if present
- Skin assessment
- Patients mobility
• Patients weight
• General health

Pressure Ulcers - NICE Quality Standard 89 (June 2015)

Pressure relieving equipment is available on a 24-hour basis. There are different processes in place dependent on location of access in Appendix 4a Community and 4b Hospital. To aid appropriate selection of pressure relieving equipment the flow chart in Appendix 5a Community and 5b Hospital is provided to assist the clinician, but does not replace clinical judgment.

The recommendations are consistent with specifications of the NICE Quality Standard 89 (June 2015)

Dynamic equipment for children in the community is provided on an individual basis through individual funding request form Bespoke Panel.

The assessment of the patient’s risk is on-going and therefore equipment can be up or down graded according to patient need. Profiling beds should also be considered to help with pressure Injury prevention and should have height adjustment and tilt facility with sufficient clearance for hoist.

High Specification Foam Mattresses
NICE recommends all vulnerable patients, including those with a stage 1-2 pressure Injury, should receive as a minimum provision, a high specification foam mattress. All beds within MDGH are provided with a high specification foam mattress as a minimum. There is a replacement policy for these foam mattresses which includes an annual audit of all foams and replacement as necessary. The Tissue Viability team undertakes this annual audit but interim assessment of these mattresses must be undertaken by the ward staff weekly to ensure the equipment is fit for purpose. High specification foams can be requested through choice equip on the community.

High Specification Foam Mattresses with heel zone (air redistributing cells)
These Mercury mattresses are specifically for patients in MGDH that are at high risk of developing pressure ulcers to the heels – evidences on assessment

Care of Foam Mattresses
• Appropriate care of the mattress is paramount in maintaining its life span and providing equipment that is fit for purpose, safe and reliable.
• The mattress and cover should be checked and cleaned between each patient.
• Unzip the mattress cover and assess the foam if it’s stained, wet, soft or crumbling it needs to be replaced.
• Mattress is to be cleaned In line with Infection Prevention and Control advice.
• Staining may indicate that the cover is no longer waterproof → potential source of infection and deterioration of the foam → implications for pressure damage.
• Any holes, tears and worn areas will allow seepage of fluid into the foam – the mattress and cover must be replaced.
• Check mattress after each patient use for contamination
• Check bed base is not wet or moldy, as this will damage the mattress.
• Do not store equipment on top of the mattress sharp points will damage the cover and foam.
• Most mattresses in MGDH are now non-turning. These are clearly marked on the covers.
• If the mattress is going into storage this must be marked as clean with the appropriate sticker
• Mattresses should be tested for bottoming-out:
  - Stand level with area normally occupied by patient’s sacrum.
  - Place open hand on either side of the area and lean forward gently trying to exert even pressure – if the bed base can be felt the mattress is ineffective and needs replacing.
  - Record a C and date on the mattress (C= condemn).
Inform Tissue Viability about any replacement problems.
For full “Infection Prevention and Control Cleaning Policy” follow the link below.

Dynamic Equipment
All equipment that requires an electrical source should be plugged in to an uninterrupted electrical supply (in the acute areas) to ensure that the equipment does not deflate due to power failure.

Alternating Pressure relieving Equipment
Type of equipment available will depend on the area of practice. Alternating equipment provided operates by alternating high pressure with no pressure. The equipment will only alternate when in operational mode. If it is adjusted to transport mode the mattress becomes static.

Each mattress will have an audible and visible alarm if any fault occurs. Faults must be responded to immediately and reported to the mattress company.

Alternating mattresses are used as routine for the majority of patients with critical care needs. Patients who require more specialist pressure relieving equipment in critical care will be provided for.

Alternating mattresses do not provide adequate pressure relief to the heels on patients that have reduced blood supply to the feet e.g. patients with Diabetes, peripheral vascular disease, neuropathy.

Dynamic low pressure therapy systems
This is for very high risk patients of developing pressure injury, or patients with existing pressure injury. It is an immersion therapy that uses continuous low pressure redistribution and the appropriate amount of immersion. These systems have a therapy zone centrally to the mattress to sense patients repositioning and alter pressures accordingly. It is essential that the sacral area is positioned within this therapy zone in order for the mattress to work effectively.

Additional Pressure Relieving Equipment
Patients at high risk of developing pressure injury to the heels a policy of “no pressure should be followed”. http://www.epuap.org/guidelines/Final_Quick_Prevention.pdf

Heel troughs or full leg pillows can be used to relieve pressure from heels (ensure pressure is not placed elsewhere and that skin is checked each shift change/ or frequently through the day, for any pressure damage).

Other equipment that may be of use to prevent pressure injury occurring are slide sheets. Correct manual handling will assist in the prevention of shear and friction that can cause skin damage.

Seating Assessment
This should be undertaken on all patients who are deemed at risk of developing pressure injury (following risk assessment) that are sitting out for any period of time. This may be undertaken by Occupational therapist or Physiotherapist or Nurse. This assessment should be recorded in the patient record.

Consider whether sitting time should be restricted to less than 2 hours per session for vulnerable patients, including patients with stage 1 and 2 pressure injury of the sacral region. It may not be appropriate to sit patients out who have any sacral injury. Record on the Care Plan length of time patient is able to sit out of bed.

If the patient is a wheelchair user and the wheelchair does not appear to meet their needs (offer enough postural support, too large or too small) please refer to the Occupational Therapist for
assessments, they will refer onto the wheelchair assessment unit if required. If the wheelchair cushion needs replacing is missing or no longer meets the patient's pressure care needs (risk levels) please refer to back to the Wheelchair Assessment Unit. If you are unsure about any of the above the Occupational Therapist or Wheelchair Assessment Unit will offer advice.

- The patient should be able to sit with their bottom right at the back of the seat and their feet flat on the floor.
- The patient's thighs should be level and their lower legs straight up and down (at 90°).
- The patient should be able to get two fingers between their knees and the front of the seat.
- The seat should be wide enough to fit the patient, but not so wide that it doesn't give them any sideways support. If it has arm rests, the patient should be able to sit between them with enough room to get their hand in on each side.
- Repositioning charts apply to patients sitting out in chairs. Monitor how long patients are sat out. Patients should be stood, mobilized, transferred out of chair (or reclined in chair if possible) as per repositioning chart.

**Adapting the seating**

If the chair is too **low**

Consider exchanging chair, or raising chair with chair raisers.

If the chair is too **high**

Consider exchanging chair or putting foot stool under patient's legs.

If the chair is too **deep**

Consider exchanging chair or support patient behind with pillows.

If the patient is **leaning** in chair

Have they been sitting out for too long?
Do they need a seating assessment?
Is the chair too wide – pillows may be needed at the sides to support posture.

**Appendix 6** Is your patient sitting comfortably. This is a poster that can be laminated and used in your clinical area but highlights the problems with poor seating.

**6.3** Keep moving

Patients who are “at risk” of developing pressure injury should change their position at least every 6 hours. If they are unable to reposition themselves record and document how often their position should be altered and assistance required to reposition. Where aids are required to reposition, document what they are and how they should be used to ensure correct usage and prevention of shear and friction.

Adults, children and neonates assessed as being “at high risk” of developing pressure injury to change their position at least every 4 hours.
Activity/repositions for at risk patients must be record for inpatients who are at risk of developing pressure injury. Patients, who have regular carers, either in their own home or care homes, may also be asked to document each positional change.

Patients who have existing pressure damage should not be repositioned on this area if at all possible.

If children and adults decline repositioning, document and discuss their reasoning for declining. Ensure that they understand the reasoning for repositioning and the implications if this doesn't happen.

6.4 Incontinence
Patients with incontinence should undergo a holistic nursing assessment; if they require specialist input ensure patients are appropriately referred.

Incontinence can increase the risk of skin breakdown therefore appropriate measures should be taken to prevent this following the “Urinary & Faecal Incontinence Skin Care management “flow chart in Appendix 7.

Within critical care, faecal incontinence may be managed with flexi-seal systems and faecal collectors, depending on individual assessment

6.5 Nutrition
Malnutrition is positively correlated with pressure Injury incidence and severity, leading to a two to three fold increase in hospital costs and length of stay.

**Individuals at risk of malnutrition:**
- Elderly
- Chronic illness
- Post surgery
- Psychiatric
- Learning difficulties
- Critical care needs

- Children
- Neurological disorders
- HIV/AIDS
- Physical disabilities
- Inflammatory bowel disease

**In line with NICE Guidelines 2014:**
Do not offer nutritional supplements specifically to prevent a pressure injury in adults, children or neonates whose nutritional intake is adequate.
Do not offer subcutaneous or intravenous fluids specifically to prevent pressure injury when the patient’s hydration status is adequate.

To prevent occurrence of pressure injury we must:

- Provide nutritional support to patients with an identified deficiency
- Base decisions on
  - nutritional assessment via recognized tool
  - general health status
  - patient preference
  - expert input (dietitian)

**When to refer to the dietitian:**

**Hospital**

All patients must be nutritionally screened within 24hrs of admission using the trust Nutritional Screening Tool.

If the patient scores 2 or more, they should be referred immediately to the dietetic department, using the dietetic referral form. The nutrition care plan, found on the Trust’s nutritional screening tool, must also be implemented immediately.

Clinical judgement should also be used when considering if a dietician referral is required. Dietitians will accept referrals from tissue viability nurses based on their clinical assessment in individual cases.

Within critical care feeding is established with 24 hours of admission to critical care (unless contraindicated) and a dietician review should take place within 48 hours.

**Community**

In the community patients at risk of malnutrition should have the food first leaflet explained to them.

If there is no improvement in nutritional intake the patients should be referred by the patients GP to the General Practice Dietician.

- In South and Vale Royal locality patients requiring a domiciliary visit or living in NH/ RH can be referred to the prescribing support dietetic service based at Leighton hospital.
- In East,
  - For domiciliary visits, the General practice dietician can attend in the relevant GP Practice clinic time. This is at the discretion and referral of the patients GP.
  - There is currently no dietetic service to NH/RH

Palliative patients can be referred the Macmillan Dieticians.

**7. Pressure Injury Management**

Following risk assessment a management plan for prevention should be devised, based on the risk assessment. This should include:

- Optimising condition of patients skin
- Reducing adverse effects of pressure, shear and friction
- Addressing external factors that will make the patient more susceptible to breakdown; inadequate nutrition and fluids, incontinence, reduction in Haemoglobin levels.
- Repositioning and redistribution
- Appropriate wound management
- Patients preference
- Patients’ involvement in self-care.
Evidence of implementation of the care plan should be documented clearly, comprehensively and accurately to show which interventions and devices are in use, the frequency of repositioning and patient outcomes and skin condition.

**Skin condition** including the state of all pressure areas **should be reassessed at each shift change** if identified at risk for patients in hospital. For patients in the community this assessment should occur ideally at each visit for patients but for patients that are visited more than weekly, a weekly skin inspection is required. Skin condition should be documented but any breaks should be treated as a wound and be assessed, staged and documented as such – (refer to wound assessment policy 2016).

### 8. Pressure Injury Wound Assessment

All pressure injury to be assessed using a structured wound assessment and follows the trust format for wound assessment.

All ulcers should be reassessed at each dressing change or at least weekly
Assessment should include measurements (unless this is documented as not appropriate e.g. malignancy). If possible use a validated measurement technique e.g. tracing/photograph.
Photographs can be used as an adjunct to wound assessment but consent needs to be obtained from the patient following trust policy.
Document an estimate of the depth of all pressure injuries and presence of undermining.
NICE C179 (2014)

### 9. Referral to Tissue Viability

It is expected that Stage 1 & 2 pressure injury will be able to be managed by the general staff in that area. If the wound deteriorates despite following this guidance then refer to Tissue Viability.
It is expected that all Stage 3 & 4 and unstagable pressure injury will be referred to Tissue Viability for advice and support. You can expect an appointment to be offered for the above patients within 3 working days of referral being received if appropriate. Telephone advice will be give prior to this if requested.

### 10. Pressure Ulcer and moisture injury reporting

**Incidence of Pressure injury** -All pressure injury staged 2 or above to be documented as an incident. This information will give the Trust its incidence data.

Please indicate on the individual patient’s notes that this has been done, so that it is not repeated if the patient is moved to another area, unless it is a new pressure injury or the pressure injury has deteriorated.

All incidents, as per the policy, are to be investigated as to reason for occurrence and what could have been done to prevent it, if at all possible. Any identified trends will be sent to Tissue Viability so issues can be addressed

If the pressure Ulcer is caused by a medical device this should be indicated on the drop down option when completing the datix.

All moisture lesions are to be reported on Datix. This is to allow the monitoring of the number of moisture lesions and any trends to be addressed.

### 11. Implementation

Dissemination of these guidelines will be through the service lines.
Implementation of the clinical information is supported through the e-learning package that is being promoted throughout the trust. This is being monitored through learning and development as part of the pressure ulcer CQUIN.

Implementation is also being supported through the “react to red campaign” which is a sustained approach to prevention across ECT.

An article will be placed in Staff Matters describing the policy

12. Education and Training
This is the central theme in the strategy for pressure injury prevention. Education is provided to support this document. Locally this is provided by the Tissue Viability Nurse, and the Learning and Development Department through direct and E-Learning training.

Direct patient and carer education, provided directly by staff and from available patient literature plays an integral part in the prevention and management of pressure injury. ECT have leaflets for pressure injury prevention and management and are available through the print room or alternatively NICE leaflets can be downloaded from www.nice.org.uk/CG029. Explanation of the leaflet should be given to each patient/carer if they are able to participate in their care. Documentation should reflect when this has been provided, and if not, why not.

13. Measuring Performance

Incident Reporting

Incidence of Pressure Injury - All pressure injury staged 2 or above to be documented as an incident. This information will give the Trust its incidence data.

Pressure ulcers are monitored through Quality strategy and are part of the CQUIN for 2016/17. The policy will be audited through Quality forum and at Trust board level by exception.

The Key Performance Indicators measured as part of this policy are:

- 65% of nursing staff to have completed the Pressure Ulcer E-learning training package by end March 2017. This will be recorded and monitored through learning and development.
- All people admitted to hospital have a pressure ulcer risk assessment undertaken within 6 hours of admission. This will be monitored through Matron documentation audits.
- All patients admitted onto the community nursing caseload will have a risk assessment undertaken on first visit. This will be monitored through the community documentation audits undertaken by service managers.
- The number of stage 2 pressure ulcers will reduce by 10% by March 2017. This will be monitored through the incident reporting system.
- Avoidable Stage 3 and 4 pressure ulcers will be held at the 2015-16 target set by commissioners and forms part of the 2016-17 CQUIN.

14. Review

This policy will be reviewed through the Quality forum. The policy will be reviewed annually against performance review and audit. These findings will identify any changes required to be made to the policy.
15. References

Cartwright. A. (2002).Nutritional assessment as part of wound management Nursing 
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adults and children. In C. D. Berdanier (Ed.), Handbook of nutrition and food:

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NHS Institute for Innovation and Improvement (2010) High Impact Actions for 
Nursing and Midwifery: The Essential Collection. Coventry: NHS III.

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Merryfield C. (2010). Nutrition and Wound Care. CN Focus; Vol 2, No. 3


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www.npuap.org/national-pressure-ulcer-advisory.panel
### MATERNITY PRESSURE AREA SCORING (MPAS) (Within 6 hrs of admission)  Appendix 1

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<tr>
<th>SPECIFICS</th>
<th>SCORE</th>
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<td>- Lower body paralysis (eg. Epidural/Spinal) &lt;4hrs</td>
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</table>

**Core Prevention:**
- Reassess MPAS when condition changes
- Prevent shear and friction on transfers at all times

**Low Risk: Score less than 5** – Encourage mobilisation/re-evaluate MPAS 2 hourly in labour/ encourage position changes

**At Risk: Score 5-15** – Position change 2 hourly, undertake skin inspection and re-evaluate MPAS 2 hourly

**High Risk Score > 15** Position change minimum 1 hourly, consider dynamic mattress post-delivery if high risk will continue for over 4 hours and unable to change position, undertake skin inspection and re-evaluate MPAS 2 hourly

(Modified from Plymouth Maternity Pressure Score Risk Assessment Scale
Jeannie Wootton(RM) /Sally Walsh (TVN) 2018)
Tissue Perfusion and Usual food intake pattern across one another adjacent bony surface slide

Shear:
Against support surfaces

Friction:
Friction/Shear exposed to moisture

Degree to which the skin is exposed to moisture

Moisture
Degree to which the skin is exposed to moisture

1. Constantly moist
Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time the patient is moved or turned

2. Very moist
Skin is often, but not always moist. Linen, nappy/pad or dressing changes every 2 to 4 hours

3. Occasionally moist
Skin is occasionally moist, Nappy/pad changes as routine. Dressing/linen change every shift (every 12hrs)

4. Rarely moist
Skin is usually dry. Routine nappy changes or patient continent. Dressing changes as routine, linen changed every 24 hrs

Friction/Shear
Friction: Occurs when skin mores against support surfaces

Shear: Occurs when skin and adjacent bony surface slide across one another

1. Significant problem
Spasticity, contracture, itching or agitation leads to almost constant thrashing and friction

2. Problem
Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequent slides down in bed or chair, requiring frequent repositioning with max. assistance

3. Potential problem
Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down

4. No apparent problem
Able to completely lift patient during a position change, moves in bed and chair independently and has sufficient muscle strength to completely lift during move. Maintains good position in bed or chair at all times

Nutrition
Usual food intake pattern

1. Very Poor
Nil by mouth and/or maintained on clear liquids, or IV's for more than 5 days OR albumin < 2.5 mg/dl OR Never eats a complete meal. Rarely eats more than ½ of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.

2. Inadequate
Is on liquid diet or tube feedings/ TPN which provide inadequate diet and minerals for age OR Albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.

3. Adequate
Is on tube feedings or TPN which provide adequate calories and minerals for age OR eats over ½ of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered

4. Excellent
Is on a normal diet providing adequate calories for age. For example: eats/drinks most of every meal/ feeding. Never refuses a meal usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.

Tissue Perfusion and Oxygenation

1. Extremely Compromised
Hypotensive (MAP<50mmh<40 in new born) OR the patient does not physiologically tolerate position changes

2. Compromised
Normotensive; Oxygen saturation may be < 95% OR haemoglobin may be < 10 mg/dl OR capillary refill may be > 2 seconds : serum pH is < 7.40

3. Adequate
Normotensive; Oxygen saturation may be< 95% OR haemoglobin may be< 10 mg/dl OR capillary refill may be above 2 secs: serum pH is normal

4. Excellent
Normotensive, Oxygen saturation > 95%, normal haemoglobin and capillary refill <2 secs.

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<td>25 + low risk</td>
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<tr>
<td></td>
<td></td>
<td>21 + medium risk</td>
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<td></td>
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<td>16 + high risk</td>
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<th>Assessment</th>
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<table>
<thead>
<tr>
<th>Mobility</th>
<th>The ability to change and control body position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>The degree of physical activity</td>
</tr>
<tr>
<td>Sensory Perception</td>
<td>The ability to respond in a developmentally appropriate way to pressure related discomfort</td>
</tr>
<tr>
<td>Moisture</td>
<td>Degree to which the skin is exposed to moisture</td>
</tr>
<tr>
<td>Friction/Shear</td>
<td>Friction: Occurs when skin moves against support surfaces</td>
</tr>
<tr>
<td>Friction:</td>
<td>Shear: Occurs when skin and adjacent bony surface slide across one another</td>
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<td>Nutrition</td>
<td>Usual food intake pattern</td>
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## Table: Moisture and Pressure Wound Related Characteristics

<table>
<thead>
<tr>
<th>Causes</th>
<th>Pressure Injury</th>
<th>Moisture lesion</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pressure and/or shear must be present.</td>
<td>Moisture must be present (e.g., shining, wet skin caused by urinary incontinence or diarrhoea)</td>
<td>If moisture and pressure/shear are simultaneously present, the lesion could be a pressure injury as well as a moisture lesion (combined lesion).</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Pressure Injury</th>
<th>Moisture lesion</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>A wound not over a bony prominence is unlikely to be a pressure injury.</td>
<td>A moisture lesion may occur over a bony prominence. However, pressure and shear should be excluded as causes, and moisture should be present. A combination of moisture and friction may cause moisture lesions in skin folds. A lesion that is limited to the anal cleft only and has a linear shape is no pressure injury and is likely to be a moisture lesion. Peri-anal redness/skin irritation is most likely to be a moisture lesion due to faeces.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Shape</th>
<th>Pressure Injury</th>
<th>Moisture lesion</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the lesion is limited to one spot, it is likely to be a pressure injury. Circular wounds or wounds with regular shape are most likely pressure injury; however, the possibility of friction injury has to be excluded.</td>
<td>Diffuse, different superficial spots are more likely to be moisture lesions. In a kissing Injury (copy lesion) at least one of the wounds is most likely caused by moisture (urine, faeces, transpiration or wound exudate).</td>
<td>Irregular wound shapes are often present in a combined lesion (pressure injury and moisture lesion). Friction on the heels may also cause a circular lesion with full thickness skin loss. The distinction between a friction and a pressure Injury should be made based on history and observation.</td>
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<th>Depth</th>
<th>Pressure Injury</th>
<th>Moisture lesion</th>
<th>Remarks</th>
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<tbody>
<tr>
<td>Partial thickness skin loss is present when only the top layer of the skin is damaged (stage 2). In full thickness skin loss, all skin layers are damaged (stage 3 or 4). If there is a full thickness skin loss and the muscular layer is intact, the lesion is a stage 3 pressure Injury. If the muscular layer is not intact, the lesion should be diagnosed as a grade 4 pressure Injury.</td>
<td>Moisture lesions are superficial (partial thickness skin loss). In cases where the moisture lesion gets infected, the depth and extent of the lesion can be enlarged/deepened extensively.</td>
<td>An abrasion is caused by friction. If friction is exerted on a moisture lesion, this will result in superficial skin loss in which skin fragments are torn and jagged.</td>
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<th>Necrosis</th>
<th>Pressure Injury</th>
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<tbody>
<tr>
<td>A black necrotic scab on a bony prominence is a pressure Injury stage 3 or 4. If there is no or limited muscular mass underlying the necrosis, the lesion is a pressure Injury grade4. Necrosis can also be considered present at the heel when the</td>
<td>There is no necrosis in a moisture lesion.</td>
<td>Necrosis starts without a sharp edge, but evolves into sharp edges. Necrosis softens up and changes colour (eg blue, brown, yellow, grey) but is never superficial.</td>
<td></td>
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<tr>
<td>Edges</td>
<td>Pressure Injury</td>
<td>Moisture lesion</td>
<td>Remarks</td>
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<tr>
<td>If the edges are distinct, the lesion is most likely to be a</td>
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<td>Moisture lesions often have diffuse or irregular edges.</td>
<td>Jagged edges are seen in moisture lesions that have been exposed to</td>
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<tr>
<td>pressure Injury. Wounds with raised edges and thickened edges are</td>
<td>pressure Injury. Wounds with raised edges and thickened edges are old</td>
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<td>old wounds.</td>
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<td>pressure Injury. Wounds with raised edges and thickened edges are</td>
<td>pressure Injury. Wounds with raised edges and thickened edges are old</td>
<td></td>
<td>friction.</td>
</tr>
<tr>
<td>old wounds.</td>
<td>wounds.</td>
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</tbody>
</table>

### Colour

| Red skin: If redness is non-blanchable, this is most likely a pressure Injury stage 1. For people with darkly pigmented skin persistent redness may manifest as blue or purple. | Red skin: If redness is non-blanchable, this is most likely a pressure Injury stage 1. For people with darkly pigmented skin persistent redness may manifest as blue or purple. | Red skin: If the redness is not uniformly distributed, the lesion is likely to be a moisture lesion. Red skin: If the redness is not uniformly distributed, the lesion is likely to be a moisture lesion. |
| Red in wound bed: If there is red tissue in the wound bed, the wound is stage 2, a stage 3 or a Stage 4 pressure Injury with granulation tissue in the wound bed. | Red in wound bed: If there is red tissue in the wound bed, the wound is stage 2, a stage 3 or a Stage 4 pressure Injury with granulation tissue in the wound bed. | Red in wound bed: If there is red tissue in the wound bed, the wound is stage 2, a stage 3 or a Stage 4 pressure Injury with granulation tissue in the wound bed. |
| Yellow in wound bed: Softened necrosis is yellow and not superficial. Slough is a creamy, thin and superficial layer; it is either a stage 3 or a stage 4 pressure Injury | Yellow in wound bed: Softened necrosis is yellow and not superficial. Slough is a creamy, thin and superficial layer; it is either a stage 3 or a stage 4 pressure Injury | Yellow in wound bed: Softened necrosis is yellow and not superficial. Slough is a creamy, thin and superficial layer; it is either a stage 3 or a stage 4 pressure Injury |
| Black in the wound bed: Black necrotic tissue in the wound bed indicates a pressure Injury stage 3 or stage 4. | Black in the wound bed: Black necrotic tissue in the wound bed indicates a pressure Injury stage 3 or stage 4. | Black in the wound bed: Black necrotic tissue in the wound bed indicates a pressure Injury stage 3 or stage 4. |

| Pink or white surrounding skin: Maceration due to moisture.          |                                                                                   |                                                                                   |
|                                                                       |                                                                                   |                                                                                   |
| Green in wound bed: Infection.                                        |                                                                                   |                                                                                   |
| Be aware that zinc oxide ointments may result in whitened skin.       |                                                                                   |                                                                                   |
To order Pressure Relieving Equipment

**Pressure Relieving Equipment Requests**

- **Complete Request form for Pressure Relieving Equipment**
  - Fax to Tissue Viability Service 01270 624944

**Monday to Friday**

- **9.00 to 5.00pm**

  - **Tissue Viability** – To approve request - may phone requester for more information regarding patient
    - Once approved by Tissue Viability Nurse
      - Admin – Order via Hill Rom Demand system

  - **Hill Rom** – Normal Requests Delivered within 24 working hours
    - End of Life Pathway – To be delivered within 4 hours

**Out of hours**

- Urgent requests for patients at the end of life and need equipment within 4 hours
  - Phone Company direct Hill Rom Tel: 01530 411000
  - Follow up with Delivery/Collection form for PR Equipment and Fax to Tissue Viability Service

**District Nurse to contact Tissue Viability if delivery timescales not achieved**

**Company to put PR equipment on bed and ensure set up correctly**

**District Nurses to review:**

- **Palliative - Weekly**
  - Short-term (under 12 weeks) – 4 weeks to 12 weeks
  - Long-term – every 12 weeks up to 24 weeks if agreed with Tissue Viability under special circumstance
MDGH/Aston - Ordering Procedures For Dynamic Mattress’s
Commencing 1\textsuperscript{st} June 2012 Hill-Rom will be the sole supplier of pressure relieving mattresses into the East Cheshire Foundation Trust.

**Ordering Products**
9.00am – 5.00pm 7days/week including bank holiday

- If following clinical assessment (and use of the flow chart) the patient requires a Primo mattress - contact Hill-Rom on 01530411000 with your request. To aid product selection, please use the trust protocol and information provided. Upon ordering you will be given a contract number please document this number in the appropriate place.

- Please supply Hill-Rom with the following Information
  - Name of person ordering the product
  - Name of the patient
  - Ward area where product is required

- Ward to keep a log of all equipment orders and collection requests for invoice and audit purposes

**Out of Hours**
5pm – 9am 7 days week/including bank holidays

For MGDH - Alternating mattresses and pressure relieving cushions are kept in the Equipment store in the undercroft. These need to be logged out when required – the person removing the equipment needs to complete the mattress log out form to communicate ward and patient. This store will be topped up each morning by Hill Rom and any removed will be invoiced in the usual way.

For Aston – 2 Spare mattresses and cushions re kept in the store room for use. The ward to contact Hill Rom with patient details if these are used and top up is required.

**Removals**
9.00am – 5.00pm 7days/week including bank holiday

All products are single patient use and should be returned to Hill-Rom for decontamination.
Please wipe down the mattress and place in the red bag provided.
(you will find this inside the foot end of the mattress).

CONTACT HILL-ROM ON - 01530411000 - PRESS 2 WHEN PROMPTED
Ensure you have the serial number to hand before calling (found on the back of each blower box/pump).

**Faults – 24 hours a day / 7 days a week**
To report a faulty product please contact Hill-Rom on 01530411000 - press 1 when prompted. Ensure you have the serial number to hand before calling (found on the back of each blower box).

A Hill-Rom technician will respond to your call by telephone to diagnose the problem and offer a course of action. It may be necessary to swap out the product

Hill-Rom 24-Hour Help Line – 01530411000
Guidance for Pressure Relieving Equipment -COMMUNITY
To be used in conjunction with clinical judgment, NICE guidance and patient preference

- At risk – Waterlow 10 +
- High Risk – Waterlow 15 +
- Very High risk – Waterlow 20 +

Has the patient signs of pressure damage? If Yes, Assess using NPUAP classification system
Grade/Stage 2 or above fill in clinical incident form

Positioning
- Consider repositioning interventions – should actively mobilise, change their position or be repositioned
- Consider restricting sitting time to < 2 hours per session. Undertake seating assessment if sitting.
- Record above using a reposition chart/schedule
- Observe for skin changes

Nutrition
- Nutritional assessment to be undertaken (alongside general assessment)
- Provide nutritional support to patients with an identified need

- No Pressure Ulcer
- Stage 1 & 2
- Stage 3 & 4

Can patient alter own position or can be repositioned easily?

- Yes
- No

- High Spec Foam
- Dynamic mattress / alternating cushion – Tissue Viability Service

If patient ‘at risk’ and patient can reposition self – may be managed on own equipment with nursing intervention

Dynamic Mattress – Max weight Patient 250kg (39st)
Cushion - Max weight Patient 115kg (18st)

Tissue Viability Service

Appendix 5a
Guidance for Pressure Relieving Equipment - MGDH/Aston - Inpatients

To be used in conjunction with clinical judgment, NICE guidance and patient preference

- At risk – Waterlow 10 +
- High Risk – Waterlow 15 +
- Very High risk – Waterlow 20 +

Has the patient signs of pressure damage? If Yes, Assess using NPUAP classification system
Grade/Stage 2 or above fill in clinical incident form

Positioning

- Consider repositioning interventions – should actively mobilise, change their position or be repositioned
- Consider restricting sitting time to < 2 hours per session. Undertake seating assessment if sitting.
- Record above using a reposition chart/schedule
- Observe for skin changes

Nutrition

- Nutritional assessment to be undertaken (alongside general assessment)
- Provide nutritional support to patients with an identified need

No Pressure Injury

Can patient alter own position or can be repositioned easily?

- Yes
  - High Spec Foam

- No
  - Stage 1 & 2
  - Stage 3 & 4

Stage 1 & 2

Patient weight up to – 250kg (up to 39st)
Dynamic Replacement mattress
Primo
- Follow Ordering Procedures

Stage 3 & 4

If Dynamic mattress is required for discharge – complete PR Equipment form at least 48hrs prior to discharge and fax to Tissue Viability 01270 624944
**IS YOUR PATIENT SITTING COMFORTABLY?**

**Sitting requires more effort than we think.**
A well designed seat helps to prevent fatigue, prevent pressure ulcers and other complaints, ensuring the body adopts the most natural posture.

**Difficulty in getting up**
It is often difficult to get up as a result of reduced muscular strength and impaired functioning of the joints. This may be caused by:
- Seat too low and/or too soft
- Inappropriate seat depth
- Large back rest angle
- Armrests too short or absent

**Shear and Friction to tissues /back pain**
Incorrect seat height can cause pressure on the bottom. An excessive slant of the back or too deep or low a seat can lead to the skeleton moving whilst the tissues try to stay in the same position causing shear and friction, back pain, and difficulty getting up.

**Intestine trouble**
An excessively low seat with an acute angle between the torso and upper legs can give rise to intestinal problems.

**Blocking of veins/nerves**
An excessively high sitting position with legs swinging can lead to veins and nerves becoming blocked causing varicose veins and sleeping legs and numbness.

**Back pain and poor posture**
Inappropriate cushioning can result in sinking and slumping back into a convex shape, contributing to back pain and other related joint and muscle ailments.
Appendix 7

Urinary & Faecal Incontinence Skin care Management

Soap and Water should not be used when cleansing following episodes of incontinence as it alters the skin's pH, which can contribute to the development of skin breakdown.

Use foam cleansers following every episode of incontinence skin cleansing, as this enables replacement of natural moisture which is lost due to the contact with urine and faeces.

Barrier creams to be used after 3rd or 4th episode of incontinence, and to be re-applied every 48-72 hours, which will protect against irritation from bodily fluids and prevent skin damage associated with incontinence.

If incontinence aids are in use such as pads ensure the patient is appropriately assessed, the correct size is in use and the absorbency is appropriate. Consider referral to continence services.
Safeguarding Process for Stage 3 & 4 Pressure Ulcers V1

All stage 3 and 4 pressure ulcers to be referred to Tissue Viability and have Datix completed (as per pressure ulcer prevention and treatment policy)

Following verification of Stage 3 or 4, Root Cause Analysis (RCA) undertaken with Head of Safety and Risk, Tissue Viability, Senior Sister or Team Leader. Unstageable pressure ulcers will be assessed and monitored on an individual basis by the tissue viability team.

If Safeguarding concern raised complete First Account Form and refer to Social Services. For acute referrals send to Hospital Social Work Team. For Community send to relevant SMART (As per safeguarding policy).

Directorate to address any issues raised from feedback by social care.

Linked Trust policies
Pressure ulcer prevention and treatment policy
Safeguarding Adults Policy

Following RCA Safeguarding concerns identified that have not already been referred to social care.

Avoidable pressure ulcer - Safeguarding issue not identified following RCA.

Unavoidable pressure ulcer - Safeguarding issue not identified.

Responsible area generates action plan to address omissions.

Health Care Professional in charge of patient at time of lapse in care to complete First Account Form. Tissue Viability to email safeguarding with patient details and WEB number.

Directorate to monitor progress and close action plan via SQS.

Responsible area to share any learning identified through RCA.
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.
Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?
Pressure Injury Prevention and Management Policy

Details of person responsible for completing the assessment:
- **Name:** Sally Walsh
- **Position:** Tissue Viability Lead Nurse
- **Team/service:** Tissue Viability

State main purpose or aim of the policy, procedure, proposal, strategy or service:
(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)
This policy is for the prevention and treatment of pressure injury for East Cheshire Trust. The aim is that there will be no avoidable pressure injury developing within the Trust (DoH high impact actions 2009). Pressure injury is often preventable and their prevention is included in domain 5 of the Department of Health’s NHS outcomes framework 2014/15 (NICE CG 179 2014).

2. Consideration of Data and Research
To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document
Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age:** East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

**Race:**
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.
Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% in 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- None: 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

Carers: In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

None known

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

No

3. Assessment of Impact
Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes ☐ No ☑
Explain your response: Policy covers all. Reference within it to patients who may have darkly pigmented skin and how to identify early skin damage.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes ☐ No ☑
Explain your response: No differential impacts identified.

DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes ☑ No ☐
Explain your response: Disabled people are more likely to develop pressure damage and reference is made to wheelchair users for prevention within the seating assessment.

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, age groups differently? Yes ☑ No ☐
Explain your response: Different National advice for different age groups but these are specifically detailed in the policy.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes ☑ No ☐
Explain your response: The policy is all inclusive and makes no differential reference.

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes ☑ No ☐
Explain your response: The policy is all inclusive and makes no differential reference.

CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? Yes ☐ No ☑
Explain your response: Advice referenced is applicable for all carers.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes [ ] No [x]  
**Explain your response:** Maternity have developed a risk assessment for women who have had a c section to ensure no pressure damage when they are less able to move around.

---

### 4. Safeguarding Assessment - CHILDREN

| a. Is there a direct or indirect impact upon children? | Yes [x] | No [ ] |

| b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:  
All children can be at risk of pressure damage and developing pressure damage can be a safeguarding concern as referenced in the policy. |

| c. If no please describe why there is considered to be no impact / significant impact on children |

---

### 5. Relevant consultation

*Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?*

The policy has gone out for consultation.  
Maternity and paediatrics will be asked for comments.

---

### 6. Date completed: 6.6.16  
Review Date: June 2019

### 7. Any actions identified:  
Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

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### 8. Approval –  
At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:  
Date: 6.6.16
### APPENDIX C - Training needs analysis

<table>
<thead>
<tr>
<th><strong>Communication/Training Plan</strong> (for all new / reviewed documents)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal/purpose of the communication/training plan</strong></td>
</tr>
<tr>
<td><strong>Target groups for the communication/training plan</strong></td>
</tr>
<tr>
<td><strong>Target numbers</strong></td>
</tr>
</tbody>
</table>
| **Methodology – how will the communication or training be carried out?** | Pressure Injury Guidelines available on MGDH Trust intranet  
Pressure Injury Guidelines available on ECT Trust intranet  
Flyers and ongoing training  
Through Link nurses |
| **Communication/training delivery** | Flyers – on going training |
| **Funding** | N/A |
| **Measurement of success. Learning outcomes and/or objectives** | Monitoring through Trust Risk Management Audits |
| **Review effectiveness – learning outputs** | Disseminate back to users and matron meeting and District Nurse Lead meetings |
| **Issue date of Document** | |
| **Start and completion date of communication/training plan** | On-going training plan |
| **Support from Learning & Development Services** | Practice Educators. Facilitate training events |