Trust Policy

University Hospitals Plymouth NHS Trust

Prevention and Management of Pressure Ulcers Policy

Issue Date	Review Date	Version
December 2020	December 2024	4

Purpose

This policy will enable compliance with current guidelines and recommendations for prevention and management of pressure ulcers, including NHS improvement and NICE guidance. Effective implementation will reduce co- morbidity enables patients to return their normal activity and home or place of care, reduce inpatient time and health care costs. The application will improve communication and ensure consistency of care across healthcare providers.

Who should read this document?

Nurses, Doctors, Health Care Assistants, Student Nurses, Physiotherapists, Therapists, Dietician and other trust healthcare workers providing patient care

Key Messages

Pressure ulcers are largely avoidable if action is taken to prevent and manage patients appropriately and at an early stage.
The following actions are needed:

- Assessment of risk
- Assessment of the skin condition
- Planning patient care based on assessment findings
- Implementation of prevention strategies with appropriate documentation
- Evaluation of patient response to risk prevention and needs management
- Consideration of safeguarding

Core accountabilities	
Owner	Tissue Viability Lead Nurse
Review	Nursing and Midwifery Operational Committee
Ratification	Chief Nurse
Dissemination (Raising Awareness)	Tissue Viability Lead Nurse
Compliance	Tissue Viability Lead Nurse
Links to other policies and procedures	

End of Life Care in Hospital Policy
Incident Management Policy
Intentional Care Record
Moving and Handling People and Objects Policy
Nutrition and Mealtimes Policy
Safe Operating procedures for moving and handling techniques of patients and objects
The Carers policy
The Management and Use of Medical Devices Policy
The Safeguarding Adults at Risk Policy
Purpose T , Skin Assessment

Version History		
1	May 2010	Initial document
2	August 2012	Revised and reformatted
3	July 2019	Revised
4	December 2020	Reviewed and updated

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Introduction

1.1. Pressure ulcers can cause significant pain and distress for patients and can contribute to longer stays in hospital, increasing the risk of complications, including infection and they also cost the NHS in the region of more than £1.4 million every day. Many pressure ulcers are avoidable if simple knowledge is provided and preventative best practice is followed.

1.2. University Hospitals Plymouth NHS Trust (UHPNT) recognises that the prevention and management of pressure ulcers are crucial to good patient outcomes and improving the patient experience.

2 Purpose

2.1. The Trust will ensure that all inpatients undergo an assessment of their physical condition on admission and all appropriate measures will be taken to prevent the development of avoidable pressure ulcers while in the care of the Trust.

2.2. Where patients are admitted with pressure ulcers or develop them in our care, treatment will be administered that prevents any further deterioration and promotes healing.

2.3. This policy is intended to establish a standardised approach and framework for healthcare professionals undertaking the care of patients (all ages) with a pressure ulcer, or at risk of developing one.

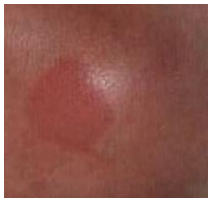
2.4. The policy and guidelines are based on current best practice statements, position documents, expert opinion, national and european guidelines and research evidence where it exists.

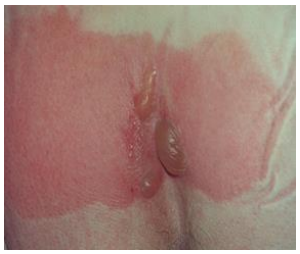
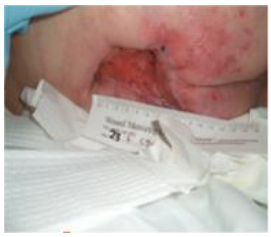
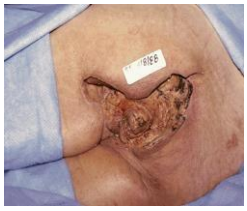
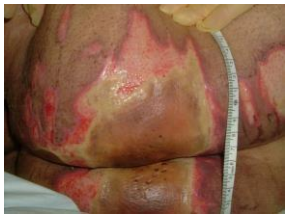
2.5. The development of pressure ulcers may in some instances be an indication of neglect by the care provider. If there is a concern that an adult at risk may have been abused or is at risk of abuse, a safeguarding adults referral must be made. It must also be recognised that some pressure ulcers may not be preventable.

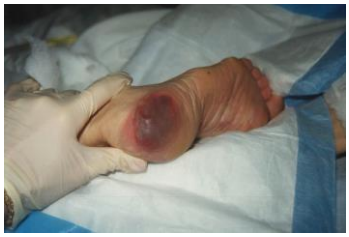
3 Definitions

3.1. A pressure ulcer is a localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other devices), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.

3.2. EPUAP/NPUAP Classification (2014)

Category 1 	**Non-blanchable erythema** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to the adjacent tissue.

Category 2 	**Partial thickness skin loss** Partial thickness skin loss of dermis presenting as a shallow ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or serosanguinous filled blister. Presents as a shiny or *dry shallow ulcer without slough or bruising*.* This stage should **not** be used to describe skin tears, tape burns, incontinence-associated dermatitis, maceration or excoriation. * Bruising indicates suspected deep tissue injury.
Category 3 	**Full thickness tissue loss**. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Category 3 pressure ulcers. The bone/tendon is not visible or directly palpable.
Stage 4 	**Full thickness tissue loss with exposed bone, tendon or muscle**. Slough or eschar may be present. Often includes undermining and tunnelling. The depth of a Category/Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Category 4 ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.
Unstageable 	**Full-thickness skin or tissue loss – depth unknown** Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined, but it will be either a

	Category/Category 3 or 4. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover" and should not be removed.
Deep tissue damage STDI 	**Depth unknown** A purple or a maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

3.1. Device Related Pressure Ulcer. A pressure ulcer that forms as a direct result of pressure/friction/shear caused by a medical device. With the exception of mucosal pressure ulcers, these should be ‘categorised’ as above.

3.2. Moisture Associated Skin Damage (MASD). Damage to the skin that occurs as a direct result of excess levels of moisture at the skin surface (e.g. urine, faeces, sweat, wound exudate).

3.3. aSSKINg Bundle. A bundle of care that addresses Assessment, Skin assessment, Surface, Keep moving, Incontinence and Nutritional needs of the patient, Giving information.

3.4. Present on Admission (POA) Pressure Ulcer. A pressure ulcer that is observed during the skin assessment undertaken on admission to that service.

3.5. New (acquired) Pressure Ulcer. The definition of a new pressure ulcer within a setting is that it is first observed within the current episode of care.

4 Duties

4.1. All clinical staff are responsible for the initial and ongoing assessment of patients for the risk of acquiring pressure ulcers, escalating and reporting any incidence of pressure ulcers or any safeguarding concerns, and for the delivery of preventative measures and treatment of pressure ulcers.

4.2. All Ward/Departmental Managers are responsible for ensuring the policy is implemented by staff in their area of responsibility, to monitor and investigate any incidence of new hospital-acquired pressure ulcer and to implement an annual action plan with specific actions if incidents occur to reduce overall incidence/incidents.

4.3. All Matrons are responsible for ensuring the policy is implemented in the area of responsibility and providing assurance to the Care Group and Service Line Management Team of compliance with the policy.

4.4. Care Groups and Service Lines must review and monitor compliance with the policy. They must identify any areas of concern and implement changes to practice where required.

4.5. The Tissue Viability Team provides support for staff implementing the policy and specialist advice where required for patient management. Monitor the effectiveness of the policy and provide support for Matrons/Ward Managers to develop and implement action plans, report to the Nursing and Midwifery Operational Committee on the effectiveness of the policy.

5 Standards- Key Performance Indicators

5.1. On admission

5.1.1. All patients will receive an assessment of their risk of developing pressure ulcers and comprehensive skin assessment as part of the overall assessment within six hours of admission and following any transfer of care i.e. ward to ward, theatre to ward.

5.1.2. The risk assessment and the findings from the assessment of the patient's skin using the EPUAP tool must be recorded in the nursing admission notes/record.

5.1.3. A clear plan of care and any interventions must be documented and should take into account the care guidance available on the risk assessment form as well as all elements of the aSSKINg bundle (HIA, 2009). If indicated intentional care rounding and appropriate documentation should be commenced.

5.1.4. The site, extent and category of any skin damage should be documented and if wound dressings are required a wound assessment/treatment chart must be used.

5.1.5. All Patients admitted with skin damage must have a clinical incident (Datix) form completed within 24 hours.

5.1.6. Consideration needs to be given to patients with skin damage and whether a safeguarding concern should be raised with the local authority.

5.1.7. All pressure ulcers should have a digital image taken, using SNAP

5.2. Prevention

5.2.1. All unit/ward nurses will develop a plan of care for all patients considered at risk of pressure damage. This plan will include, pressure relieving equipment, positioning schedules, skin care requirements (including continence management), moving and handling needs and nutritional requirements (See NICE clinical guideline CG179 for further advice)

. Consideration needs to be given to all aspects of the aSSKINg bundle and where necessary ongoing use of intentional rounding.

5.2.2. The plan of care will take into consideration the findings of the risk assessment, patient comfort and acceptability, critical care needs, patient weight (BMI) and MUST assessment, general health, skin assessment, continence issues and any safety issues.

5.2.3. If equipment required is not in place within 6 hours a clear plan of care be documented which includes actions taken to minimise the risk of damage (eg. increased frequency of repositioning) and the plan for obtaining equipment. All patients who are deemed at risk should as a **minimum** be placed upon a high specification foam mattress.

5.2.4. Staff will seek specialist advice as appropriate, e.g. manual handling, dietician, tissue viability team. All staff will document when they have referred the patient in the nursing notes. When the specialist advice has been provided the nurse will ensure it is incorporated into the patient's plan of care within 24 hours.

5.2.5. A Waterlow risk or Purpose T risk assessment and skin assessment will be documented daily (and if the patient's clinical condition changes significantly) and the care plan updated to reflect any changes.

5.3. Treatment

5.3.1. All patients with pressure damage must have a datix incident form completed within 24 hours. A referral to tissue viability using the internal referral form on SALUS must be made for all patients with category 3, 4, or unstageable pressure ulcers, or DTI and this should be accompanied by a digital image of the wound.

5.3.2. Once pressure damage has been identified it must be reassessed on each dressing change using the EPUAP grading tool; this should at the very least be twice a week unless the patient is only having weekly dressing changes. However, the patient's overall skin condition should be examined each shift, using the EPUAP tool as guidance. All findings must be recorded in the nursing notes.

5.3.3. Wound documentation will include wound dimensions, using ruler measurements. This can be supported by body mapping, medical photography or SNAP photography images uploaded electronically at ward level. A wound assessment chart must be completed.

5.3.4. The ward/unit nurse responsible for the patient must ensure a plan of care is provided, detailing measures to prevent further damage and assist with the treatment. This plan will include, for example, use of self-care strategies, pressure relieving equipment, positioning schedules, skin care requirements, moving and handling needs, nutritional and wound care requirements. Specialist advice on treatments to be sought as required.

5.3.5. Nutrition and hydration is key in healing pressure ulcers. If food intake remains low refer to a dietitian.

5.4 Patient and Carer participation

5.4.1 Staff will actively encourage patients/carers to participate in the prevention and treatment of those at risk of pressure damage. This will encompass strategies of repositioning, skin observation, safe use of the equipment and passive exercises.

5.4.2 Staff will utilise a range of information resources to assist with this process, for example, the tissue viability resource file or link nurses. All interventions and education must be clearly documented in the nursing care record.

5.4.3 The carer's policy should be referred to in all instances when pressure ulcer prevention or treatment is delegated to a carer. That care remains the responsibility of the registered practitioner, as does the communication and support of that carer in their caring role on the ward. All agreed on care to be delivered by the carer must be documented and evaluated in the patient's care plan.

5.5 Non Concordance

5.5.1 Each time a patient declines to be repositioned it must be clearly documented in the nursing notes. Patients must continue to be offered to reposition in accordance with their risk assessment.

5.5.2 A patient who declines to reposition more than 2 times in succession should be reviewed by the ward manager or their delegated deputy.

5.5.3 Reasons for non-concordance must be addressed and dealt with if possible i.e. pain when moving - patients may need analgesia to facilitate regular repositioning.

5.5.4 The plan of care should also be discussed with the patient, their family and or carers, including an explanation of the risk and potential outcomes, with clear documentation in the patient's clinical record that this has been done and that the patient, their family and carers where applicable understand those risks and potential outcomes.

5.5.5 A referral to tissue viability should be made at an early stage for any patient who is non-concordant with their repositioning care plan.

5.6 End of life care

5.6.1 For patients in the Last Days of Life, every effort should be made to continue to undertake regular total skin assessment and full implementation of the aSSKINg bundle as part of an individualised care plan and taking into account the wishes of the patient, their family and carers as applicable.

5.7 Education

5.7.1 Staff involved in caring for patients at risk of developing, or who have developed a pressure ulcer have a professional responsibility to ensure that they attend training in pressure ulcer prevention and treatment.

5.7.2 The Tissue Viability team offer update sessions in pressure ulcer assessment and treatment on a regular basis which staff can book on to.

5.7.3 A designated registered nurse and unregistered nurse will act as ward link nurses and attend the nurse link meetings.

5.7.4 All clinical staff to complete induction pressure ulcer prevention training including the aSSKINg UHP teaching video

5.8 Safeguarding

5.8.1 The guidance issued by the Department of Health and Social Care (January 2018) in the document *Safeguarding Adults Protocol: Pressure Ulcers and the interface with a safeguarding enquiry* should be followed. The adult safeguarding support tool within this document should be used to aid any decision about whether to raise a safeguarding adults concern with the local authority.

5.8.2 For all Category 3 & 4, Suspected deep tissue injuries and Unstageable pressure ulcers the Duty of Candour policy needs to be followed; refer to incident management policy.

5.9 Discharging patients with pressure ulcers or other skin damage

5.9.1 A patient who is deemed 'at risk' of developing a pressure ulcer or other skin damage should have a total skin assessment on the day of discharge.

5.9.2 A patient with a pressure ulcer or other skin damage should be discharged with a documented wound care assessment and plan and this will be recorded in the patient's notes. An image should be taken of the wound, either using SNAP the day of discharge.

5.9.3 A patient discharged with a pressure ulcer should be referred for further assessment by the community team(s). This referral should be documented in the patient's notes.

6 Overall Responsibility for the Document

6.1. The Tissue Viability Lead Nurse has overall responsibility for developing this policy in consultation with other relevant clinical staff.

6.2. Responsibility for implementation of this policy lies with clinical teams within Care Groups.

6.3. This policy will be reviewed in line with Trust Policy of five years and earlier if any significant changes are indicated.

7 Consultation and Ratification

7.1. The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

7.2. The review period for this document is set as a default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

7.3. This document will be approved by the Nursing and Midwifery Operational Committee and ratified by the Chief Nurse.

7.4. Non-significant amendments to this document may be made, under delegated authority from the Chief Nurse, by the nominated author. These must be ratified by the Chief Nurse and should be reported, retrospectively, to the approving board.

7.5. Significant reviews and revisions to this document will include a consultation with named groups across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or categories that are directly affected by the proposed changes.

8 Dissemination and Implementation

8.1. Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process.

8.2. Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

8.3. The document author(s) will be responsible for agreeing on the training requirements associated with the newly ratified document with the Chief Nurse and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

9.1. Incident Reporting of New Pressure Ulcers (Hospital Acquired) category 2-4. This information is available for Ward Managers / Matrons to review and trends will be reported back to Ward areas and Harm Free Care Group on a monthly basis by the Tissue Viability team.

9.2. Hospital Acquired Pressure Ulcers : All category 3 and 4, suspected deep tissue injury and unstageable new hospital-acquired pressure ulcers are subject to consideration as Serious Incidents Requiring Investigation (SIRI), and following the Trust policy for investigation and reporting will require and either a concise or full RCA determined by the level of harm to the patient including the impact on their quality of life. As part of this process, an interim review meeting will be undertaken with the Chief Nurse (or nominated Deputy), Tissue Viability Lead Nurse and the Matron and Ward manager for the area involved, with consideration for Safeguarding Named Nurse attendance too. The root cause analysis and learning points will be reviewed at the Harm Free Care Group and disseminated across the trust.

9.3. Process monitoring will be undertaken by Ward Managers/Matrons as part of the regular audits using Meridian. Ward Managers/Matrons will be responsible for implementing any remedial actions required, with support from the tissue viability team as needed.

9.4. The Trust will meet any statutory requirements for data collection/audit to meet external requirements (e.g. Patient Safety Thermometer) and action plans agreed

at ward level dependent on results.

10 References and Associated Documentation

- European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel (2019) *Pressure Ulcer Guidelines.* Washington DC: National Pressure Ulcer Advisory Panel
- DoH, Department of Health, (2010) Essence of Care; Benchmarks for Prevention & Management of Pressure ulcers. The Stationary Office, London.
- Plymouth Diabetes Health Community web site: www.plymouthdiabetes.org.uk
- National Institute of Clinical Excellence, NICE (cg119) March 2011 Diabetic Foot problems Inpatient management
- Pressure ulcers: prevention and management **(NICE)** Clinical guideline [CG179] Published April 2014 https://www.nice.org.uk/guidance/cg179/resources/pressure-ulcers-prevention-and-management-pdf-35109760631749 (accessed 26/06/19)
- Department of Health and Social Care (2018): Safeguarding Adults Protocol-Pressure Ulcers and the interface with a Safeguarding Enquiry.
- Langer, G. & Fink, A 2014 Nutritional interventions for preventing and treating pressure ulcers

(Review) Cochrane Database Systematic Reviews Issue 6. Art. No.: CD003216. DOI:

10.1002/14651858.CD003216.pub2.

- NICE 2014. Pressure ulcer: prevention and management of pressure ulcers. NICE clinical guideline

179; www.guidance.nice.org.uk/cg179

Dissemination Plan and Review Checklist | Appendix 1

Dissemination Plan	
Document Title	**Prevention and Management of Pressure Ulcers**
Date Finalised	July 2019
Previous Documents	
Action to retrieve old copies	

Dissemination Plan

Recipient(s)	When	How	Responsibility
All Trust staff	July 2019	IG StaffNet Page	Information Governance Team
Tissue Viability Link Nurses	July 2019	Email & hard copy for Ward/Department resource file	Lead Nurse for Tissue Viability
Matrons/Ward Managers	July 2019	Email	Lead Nurse for Tissue Viability

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes

Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment | Appendix 2

Core Information	
Date	December 2020
Title	Prevention and Management of Pressure Ulcers Policy
What are the aims, objectives & projected outcomes?	To ensure compliance with the external guidance and recommendations for prevention and management of pressure ulcers. Implementation will reduce co-morbidity, enable patients to return their normal activity and home or place of care, reduce inpatient time and health care costs. The application will improve communication and ensure consistency of care across healthcare providers

Scope of the assessment
Pressure ulcer prevention forms a key part of clinical care for patients in all areas of the Trust and all clinical staff are expected to take responsibility for ensuring all appropriate measures are taken to minimise risk.

Collecting data	
Race	There is no evidence to suggest that there is an impact on race regarding this policy. However, data collected from Datix incident reporting and complaints will ensure this is monitored. Consideration will be made if the information provided is required in a different language.
Religion	There is no evidence to suggest that there is an impact on religion or belief and non-belief regarding this policy. However, data collected from Datix incident reporting and complaints will ensure this is monitored. The plan of care for patients includes nutritional requirements which may relate to specific religious beliefs.
Disability	There is no evidence to suggest that there is an impact on disability regarding this policy. However, data collected from Datix incident reporting and complaints will ensure this is monitored. The document considers issues that may be identified in the plan of care for patients and recommendations will be made as required Consideration will be made if the information is required in different formats or the translation services are required. Consideration has been made for vulnerable adults and mental health and learning disability issues will be highlighted within the care plan as appropriate.

Sex	There is no evidence to suggest that there is an impact on sex regarding this policy. However, data collected from Datix incident reporting and complaints will ensure this is monitored.
Gender Identity	There is no evidence to suggest that there is an impact on gender identity regarding this policy. • However, data collected from Datix incident reporting and complaints will ensure this is monitored.
Sexual Orientation	There is no evidence to suggest that there is an impact on sexual orientation regarding this policy. However, data collected from Datix incident reporting and complaints will ensure this is monitored.
Age	There is no evidence to suggest that there is an impact on age regarding this policy. However, data collected from Datix incident reporting and complaints will ensure this is monitored.
Socio-Economic	There is no evidence to suggest that there is an impact on socio-economic regarding this policy. However, data collected from Datix incident reporting and complaints will ensure this is monitored.
Human Rights	The document has considered safeguarding issues which will be addressed following the Trust safeguarding processes. Informal carers will be encouraged to participate in the prevention and treatment as required. Data collected from Datix incident reporting and complaints will ensure this is monitored.
What are the overall trends/patterns in the above data?	No comparative data have been used to date which means that no trends or patterns have been identified
Specific issues and data gaps that may need to be addressed through consultation or further research	No gaps have been identified at this stage but this will be monitored via data collected from datix incident reporting and complaints.

Involving and consulting stakeholders	
Internal involvement and consultation	Matrons Ward Managers Specialist Staff – vascular, diabetes, plastic surgery Tissue viability & link nurses Chief Nurse Equality & Diversity Lead
External involvement and consultation	
Impact Assessment	
Overall assessment and analysis of the evidence	Consideration will be made if the information provided is required in a different language. The plan of care for patients includes nutritional requirements which may relate to specific religious beliefs. The document considers issues that may be identified in the plan of care for patients and recommendations will be made as required Consideration will be made if the information is required in different formats or the translation services are required. Consideration has been made for vulnerable adults and mental health and learning disability issues will be highlighted within the care plan as appropriate. The document has considered safeguarding issues which will be addressed following the Trust safeguarding processes. Informal carers will be encouraged to participate in the prevention and treatment as required.

Action Plan

Action	Owner	Risks	Completion Date	Progress update