1. Purpose

This purpose of this policy is to promote evidence based care to help prevent the development of pressure ulcers for all patients across Torbay and South Devon NHS Foundation Trust (TSDFT), hereby referred to as “The Trust”. This applies to all vulnerable individuals of all age groups.
2. **Introduction**

2.1 This policy aims to standardise care, be equitable and accessible to all healthcare professional and carers by:

   i. Preventing the development of pressure ulcers.
   
   ii. Implementing individualised treatment plans to manage existing pressure ulcers effectively.
   
   iii. Standardising the assessment and management of individuals who are at risk of developing pressure ulcers or who have existing pressure ulcers.
   
   iv. Supporting families, carers and healthcare professionals with a framework for the prevention and management of pressure ulcers.


2.2 Pressure ulcers cause considerable harm to patients, hindering recovery, frequently causing pain and can potentially lead to the development of serious infections. Pressure ulcers have also been associated with an extended length of hospital stay, sepsis and mortality.

2.3 Early detection of skin damage and implementation of adequate preventative strategies can prevent tissue damage altogether or reduce the seriousness of the ulceration.

2.4 The reduction of pressure ulcers developed in our care is a quality indicator.

3. **Roles and Responsibilities**

3.1 The Trust shall provide access to training for all staff providing direct patient care in order to maintain their competence in pressure ulcer prevention. Training will include risk assessment, skin assessment, grading/categories, recording and reporting pressure ulcers, seating, provision and use of equipment.

3.2 The Trust shall ensure that a variety of pressures relieving devices are available for all patients assessed as requiring them.

3.3 The Trust shall provide appropriate, high specification pressure reducing foam mattresses and seating to all patients at risk of developing pressure ulcers in hospital.

3.4 When patients are moved to other care facilities it is the responsibility of the discharging/transferring organisation to ensure that adequate pressure ulcer prevention equipment will be requested by the receiving organisation.

4. **Pressure Ulcer Prevention**

4.1 A pressure ulcer is localised injury to the skin and/or underlying tissue, usually over a bony prominence as a result of pressure or pressure in combination with shear or friction. A number of contributing factors are recognised as increasing the risk of an individual developing a pressure ulcer.
4.2 Contributing factors which increase a patient/clients vulnerability to tissue damage include;

i. Patient posture, fixed flexion of limbs and level of mobility.
ii. Skin condition e.g. dry or anhidrotic, excessive moisture or incontinence.
iii. Level of consciousness or sensory impairment.
iv. Acute, chronic and terminal illness or other co-morbidities (for example, sepsis, reduced blood supply, pain, medication, organ failure, reduced sensation/neuropathy).
v. Extremes of age.
vi. Nutrition and hydration status and extremes of BMI.
vii. History of previous pressure damage.
viii. Patients’ mental health, capacity, cognition and psychosocial status.
ix. Dry/anhidrotic skin.

5. Risk Assessment

5.1 The assessment, which should be undertaken within four hours of admission to Trust and Community Hospitals or at initial assessment for community based patients, should be carried out by a healthcare professional that has had the appropriate training.

5.2 Risk assessment will be informal, using clinical experience and simple prompts and followed by a formal assessment using a validated risk assessment tool.

5.3 Both informal and formal risk assessment should be repeated each time the patients’ condition or circumstances change, e.g. goes to theatre, falls, change in diet and fluid intake, develops infection. Routine review in a stable patient is recommended weekly in community hospitals and monthly in community settings.

5.4 Risk assessment tools encourage a structured approach to assessment, complement experienced nurses' judgement and act as an aide memoir for less experienced clinicians, but should not be used to prescribe equipment or treatment.

5.5 The use of assessment tools has been demonstrated to increase the intensity and effectiveness of prevention interventions when a care plan is developed to include reducing the impact of pressure and shear in conjunction with other issues such as immobility, poor nutrition, etc.

5.6 Refer to Waterlow risk assessment tool

5.7 In addition to skin assessment, activity and mobility, nutrition, impact of contributing factors such as tissue perfusion and oxygenation, moisture, advanced age and sensory damage must be taken into consideration.

5.8 The aim of best practice is to use the SSKIN (Support Surface, Skin inspection, Keep moving, Incontinence, Nutrition and Hydration) bundle as part of the integrated approach to pressure ulcer prevention.

6. Skin Assessment

6.1 The patient’s skin condition should be assessed using the Waterlow Risk Assessment tool and recorded within four hours of admission or first contact.
In the Emergency Department the Blanching tool must be completed electronically as soon as possible after admission and within 2 hours.
If the patient is housebound the assessment should be completed at the first visit then regularly (i.e., at least monthly) during a period of care. The frequency of reassessment should be based on the patient’s vulnerability and changes in medical condition, but daily skin assessment should be viewed as a minimum standard for hospital patients.

6.2 All bony prominences should be checked with patients and their carers given appropriate information to enable them to perform regular skin checks.

6.3 Check for:

i. Persistent erythema, i.e. redness over a bony prominence that does not fade within 2 hours.

ii. Non-blanching erythema, i.e. a persistent area of redness over a bony prominence that does not turn white or blanch when light finger pressure is applied and then return to the original colour.

iii. Blisters.

iv. Dusky patches or skin over a bony area that looks bruised.

v. Localised heat, localised oedema localised induration (hardness within the tissue) or localised coolness if tissue death occurs may be noted in darker skin tones.

vi. Ask the patient if they can identify any areas of pain or discomfort that might be attributed to pressure damage especially when using plaster casts or splint. Pain over a bony area may be a precursor to tissue breakdown.

vii. Observe for skin damage that could be caused by medical devices, e.g. catheters, oxygen masks, pulse oximeter sensors.

viii. Record all skin assessments, noting details of any painful areas possibly related to pressure damage.

Refer to the [Nursing Evaluation form](#).

7. Preventing Damage to the Skin

7.1 Caring for the skin is every health professional’s responsibility. In order to keep it in good condition the skin needs to be protected from maceration, irritation, the removal of natural oils and accidental damage. Treatment of the skin therefore depends on the state in which it is found, rather than any routine procedure.

7.2 Consider the following principles in caring for the skin:

i. Keep it clean.

ii. Do not let it remain wet as excessive moisture e.g. urine, faeces, perspiration, wound exudate, saliva leads to maceration and increases the effects of shear and friction.

iii. Do not let it dry out.

iv. Prevent accidental damage.

7.3 To achieve the above:

i. Minimise irritation and dryness of the skin by regular monitoring and cleansing with a mild cleanser or a hydrating cream.

ii. Emollients or moisturisers can be applied to help prevent skin dehydration.

iii. Avoid talcum powder as this can ‘cake’ and cause irritation and friction.

iv. Reduce the effect of moisture on the skin. Skin barrier products which are on formulary and compatible with many continence aids, may be applied according to manufacturer’s instructions.

v. Ensure adequate nutritional and fluid intake.
7.4 Do not massage or vigorously rub skin to prevent pressure ulcers as there is a possibility of damage to localised blood vessels and tearing fragile skin.

8. Repositioning

8.1 Dependant on individual need all staff will adopt a twenty-four hour approach to pressure relief. Patients will require a repositioning schedule that is responsive to their requirements and the frequency of reposition will be reviewed on a regular basis.

8.2 Nice Clinical guideline CG179 (2014) guidelines recommend repositioning 4-6 hourly as a minimum standard.

8.3 Where patients have been identified as “at risk” of developing pressure ulcers, the risk can be reduced by the immediate use of a repositioning schedule, especially if waiting for provision of more specialised equipment. The aim of repositioning is to reduce the duration and magnitude of pressure over vulnerable areas of the body.

8.4 Consider mobilising, positioning and repositioning interventions for all patients (including those in beds, chairs, and wheelchair users). The frequency of repositioning will be influenced by variables concerning the individual and the support surface in use.

8.5 Use good positioning, transferring and turning techniques and appropriate equipment when repositioning patients to minimise pressure, shear, friction and patient discomfort.

8.6 Repositioning should be undertaken using the 30 degree tilt. Avoid full 90 degree turns from side to side i.e. one hip to another.

8.7 If appropriate use an electric profiling bed frame to assist with repositioning. Reduce pressure and shearing forces by lowering the back rest on bed frames and trolleys to about 30 degrees depending on patient condition. A combination of reducing the elevation of the back rest and a 30 degree elevation of the foot end of the bed will also reduce shearing and friction forces caused by patients slipping down in bed.

8.8 Use pillows or foam wedges or other appropriate devices to avoid contact between bony prominences such as knees and ankles.

8.9 Record repositioning regimes, specifying frequency and position adopted and include an evaluation of the repositioning regime. Utilise intentional rounding documentation if deemed appropriate.

8.10 Avoid positioning the patient onto a reddened area or existing pressure ulcer. The redness will indicate that the tissue has not recovered and will be easily damaged if further pressure is applied.

8.11 The time a patient spends in a chair should be limited dependent upon the known risk of pressure ulcers, skin condition, equipment available and the ability to change their own position. Patients “at risk” from pressure damage and those patients with existing pressure damage, who cannot relieve their own pressure independently, should restrict chair sitting to a maximum of 2 hours at any one time.

8.12 Seek specialist advice (i.e. Tissue Viability/ Occupational Therapist etc.) regarding equipment for individual patients where repositioning and offloading is challenging.

8.13 All equipment used to assist with pressure ulcer prevention should be checked to ensure that it is clean, has been maintained and is in good working order before being issued to a patient.
and checked daily thereafter in line with the SSKIN bundle. When using dynamic moving air mattresses this should include constant monitoring to ensure the appropriate comfort or weight setting is being used, the ‘static’ mode is not turned on inappropriately and the mattress has not deflated under the patient (See Medical Devices Policy). Refer to Infection Control Policy for cleaning and decontamination of medical equipment.

9. Nutrition

9.1 It is widely agreed that impaired nutrition and hydration will influence tissue vulnerability to extrinsic factors such as pressure.

9.2 Malnutrition occurs when an individual’s dietary intake fails to meet the patient’s metabolic requirements. Acute and chronic illness, pain and cognitive impairment are often associated with poor nutritional status and pressure ulcer development. Infection and the wound healing process increase calorific demands.

9.3 Refer to TSDFT policies: Nutrition Risk Screening ref no 0526.

10. Record Keeping

10.1 Many pressure ulcers are avoidable so comprehensive record keeping is of paramount importance as development of pressure ulcers may result in complaints, safeguarding and governance investigations.

10.2 The judgement as to whether the pressure ulcer was avoidable will be based on the evidence available which identifies the prevention and treatment strategies provided for each individual patient compared with best practice guidelines. Therefore compliance with the guidelines must be recorded in the patient’s medical records using the SSKIN bundle.

10.3 Record:

i. Risk assessment and regular reassessment using SSKIN bundle where appropriate.

ii. Skin condition and body map of any tissue damage.

iii. The anatomical position of any tissue damage.

iv. Size of the wound i.e. length, width and depth if possible.

v. Grade/category of the pressure ulcer using the NPUAP/EPUAP Pressure Ulcer Classification System.

vi. Pressure ulcer prevention interventions including repositioning, frequency of repositioning and all equipment provided.

vii. Patient’s feelings and ability to comply with interventions (this could be referenced against SSKIN Bundle).

10.4 Support records with regular photographs (taken with consent) and/or tracings calibrated with a ruler (NICE quality marker). Ensure the photograph is labelled clearly with patient’s initials, NHS number, date and anatomical position of the wound.

Photographic records made for clinical purposes form part of a patient’s record. Please see the consent policy.

Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient’s care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient.
Photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication. Consent can be given verbally except where the photographic record may be used in any form of publication where written consent is required.

10.5 All pressure ulcers, grade 1 and above, must be reported as a clinical incident for Acute and Community Hospitals. All other Community Services are required to report pressure damage of grade 2 and above.

10.6 Patients who are unwilling or unable to comply with advice and who have capacity need to complete the risk, choice, control and enablement process in the Community Service Unit. This ensures the risks the patient is choosing to take are clearly recorded and the patient understands the potential or actual consequences.

11. Pressure Ulcer Grading/Categories

11.1 Category or grading are terms that refer to a recording system that can indicate the severity of a pressure ulcer based on the type of tissue involved.

11.2 The purpose of adopting a grading/categorising tool is to use a structured system to help achieve an objective description of the type of tissue involved and therefore assess the severity of the tissue damage. A structured system will improve record keeping, communication and the quality of patient care. This will assist with care planning, and can be used for clinical audit and in clinical trials.

11.3 The NPUAP/EPUAP Pressure Ulcers Classification System [2014] is the classification tool that staff are required to use across TSDFT.

11.4 Refer to NPUAP/EPUAP Pressure Ulcers Classification.

11.5 Skin damage that can be attributed to incontinence or moisture alone should be recorded as a moisture lesion.

11.6 There is often confusion in recognising a pressure ulcer and a lesion caused by moisture which is usually associated with incontinence. The differentiation is important as patient outcomes may be adversely affected since prevention and treatment strategies may differ. If in doubt always seek advice from a more experienced colleague or the Tissue Viability service.

11.7 Skin damage that can be attributed to pressure, shear or friction should be recorded as a pressure ulcer.

11.8 Do not use a classification system in reverse order to describe improvement in an ulcer. Whilst pressure ulcers heal progressively to a more shallow depth, they do not replace lost muscle, subcutaneous fat or dermis before they re-epithelialize. Refer to Wound Related Characteristics table to differentiate between pressure ulcers and moisture lesions.
12. **Reporting of Pressure Ulcers**

12.1 All pressure ulcers on identification must be recorded as a clinical incident using the appropriate incident reporting system.

12.2 Always consider safeguarding if there are any concerns that the pressure ulcer has resulted from abuse or neglect and report this as per the flow chart on the Trust intranet, ICON (Integrated Care Organisation Network). When the incident form is reviewed by the incident reviewer/manager, they will also carefully consider any safeguarding issues and, where required, the reviewer/manager will then report through to the relevant safeguarding team.

12.3 Pressure ulcers identified as Grade/Category 3 or 4, which have been acquired whilst the patient/service user is under the care of TSDFT, are classed as a ‘Serious Incident Requiring Investigation’ (SIRI). These must be reported onto the incident reporting system within two working days of the pressure ulcer being identified to enable compliance with the NHS Incident reporting framework for a SIRI if subsequently classed as ‘avoidable’.

12.4 The Incident management team will then send a request for a chronology (SSKIN Chronology or full chronology) to be completed within 2 working days. Once received, the Tissue Viability Team in collaboration with the Incident team will determine if the pressure ulcer is ‘Avoidable or ‘Un-avoidable’. If the Grade 3 or 4 is classed is ‘Avoidable’ then a Root Cause Analysis (RCA) investigation will be instigated and the SIRI reported onto the Strategic Executive Information System (STEIS).

12.5 An urgent referral should be made to the Tissue Viability Service for all Grade/Category 3 and 4 pressure ulcers.

12.6 The Tissue Viability Service will be informed by automatic email of any Grade 3 and 4 pressure ulcers that are reported on the incident reporting system. The TV Service will monitor if a referral has been made to the service and report advice given to the nominated investigator.

12.7 All Grade 3 or 4 pressure ulcers that have been acquired whilst in our care and identified as ‘avoidable’ following the completing of a chronology, will require an RCA Investigation. Templates for these will be attached to the incident report for the use by the investigator. The incident management team will ensure that the investigator is provided with the correct template to use. Copies of these are also available on the ICON website.

12.8 All Grade 3 and 4 avoidable pressure ulcers, acquired in our care, will be reported onto STEIS. The RCA investigation must be completed within 60 working days of the date it is reported onto STEIS.

13. **Avoidable Pressure Ulcer**

13.1 “Avoidable pressure damage” suggests that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:

- i. Evaluate the person’s clinical condition and pressure ulcer risk factors;
- ii. Plan and implement interventions that are consistent with the person’s needs and goals, and recognised standards of practice;
- iii. Monitor and evaluate the impact of the interventions or revise the interventions as appropriate.
14. **Unavoidable Pressure Ulcer**

14.1 “Unavoidable pressure damage” suggests that the person receiving care developed a pressure ulcer even though the provider of the care had;

i. Evaluated the person’s clinical condition and pressure ulcer risk factors;
ii. Monitored and evaluated the impact of the interventions and revised the approaches as appropriate.
iii. The patient refused to adhere or was unable to adhere to prevention strategies in spite of education of the consequences of non-adherence as evidenced by the risk choice, control and enablement documents.

14.2 It must be acknowledged that there are patients for whom unavoidable pressure ulcers may occur.

14.3 Physical and social factors which may contribute to unavoidable pressure ulceration are:

i. Haemodynamic therapy requiring immobility for long periods of time (dialysis, scans etc.).
ii. Spinal instability precluding turning or repositioning.
iii. Patients refusing to be repositioned.
iv. Patients following an end of life pathway may be unable to tolerate repositioning as frequently as their skin requires.
v. The patient has not previously been seen by a Health Care Professional.
vi. The patient has mental capacity but refused assessment and/or treatment even when initial assessment has evidenced signs of pressure damage, or has not complied with the agreed plan of care.

vii. The patient is known to a healthcare professional but an acute/critical event occurs which affects mobility or the ability to reposition; for example the patient being undiscovered for a period following a fall or loss of consciousness.

15. **Provision of Equipment**

15.1. Choose pressure relieving devices following a holistic patient assessment and a comprehensive risk assessment. This will include pressure ulcer assessment, severity and location of the wound, cause of the pressure ulcer if present, skin assessment, medical condition, treatment priorities and patient weight. Patients will require a repositioning regime and offloading of at risk heels even when they are being nursed on an alternating mattress.

Patients should, when possible, be actively involved in the care process and the selection of the most suitable equipment for their needs

Patients have a right to decline treatment and their decision must be respected. It may be advisable to complete a mental capacity assessment. Some patients may refuse to use the equipment that has been recommended particularly if the use of that equipment affects their independence. The patient’s reason for refusal should be explored and alternative strategies in agreement with the patient.

15.2. If provision of pressure relieving equipment is required on a long term basis the following factors should be considered; the care setting, acceptability and comfort, the patient’s life style and abilities and the availability of carer/healthcare professionals to reposition the patient.

15.3. Ensure the mattress is compatible with the bed frame and all other equipment that is required, i.e. bed rails, hoists, etc.
15.4. Provide pressure relieving cushions for patients who are unable to reposition themselves whilst sitting in a chair.

15.5. In children, ensure:
   
i. Appropriate cell size mattress.
   
ii. Appropriate position of pressure sensors within mattress in relation to the child.
   
iii. Monitoring of use of alternating pressure mattresses with a permanently inflated head end in young children to avoid occipital damage.

15.6. There is no single type of pressure relieving device that is suitable for all patients so seek advice from your relevant Tissue Viability Service, Podiatry Service or Occupational Therapist.

15.7. All equipment used to assist with pressure ulcer prevention should be checked to ensure that it is clean and in good working order before being issued to a patient. Daily checks must be undertaken thereafter in line with the infection control policy.

15.8. Staff require the appropriate knowledge and education prior to the requisition of equipment provision and must be trained in its safe use and assembly. In community settings equipment will be prescribed and accessed via the relevant central equipment store, dependent upon geographical area.

16. Prevention of Heel Pressure Ulcers

16.1. The shape of the heel makes it more difficult to reduce pressure as the calcaneus bone has a pointed shape with little subcutaneous fat, therefore “total offloading” is recommended to lift the heel directly off the bed, and footstool etc. “Total offloading” is preferable and more effective than any dynamic air mattress.

16.2. In addition to the standard skin assessment, patients who are especially vulnerable to developing heel ulcers, e.g. patients with diabetes and/or peripheral vascular disease or who have reduced sensation in lower limbs should have a basic vascular assessment using the Ipswich Touch Toe Test. Patients having lower limb surgery would be assessed by the secondary care team.

16.3. Check feet daily for colour, warmth and sensation using the Ipswich Touch Toe Test. Check capillary refill times and that good pedal pulses are present, using a hand held Doppler if required.

16.4. To ensure “total offloading” of pressure from the heels, protection devices should elevate the heel in such a way as to distribute the weight of the leg along the calf without putting pressure on the Achilles tendon. The knee should be in slight flexion.

16.5. A good quality pillow to raise and maintain the heel off the mattress is often just as effective as a sophisticated device, however specialist equipment such as leg troughs and specialist boots and shoes are available.

16.6. Do not use donut or ring type pressure relieving devices as these can alter tissue interface pressures. Natural sheepskin can reduce friction over bony prominences but is not effective in relieving pressure in immobile patients.
17. Training and Supervision

17.1. All staff involved in actual patient care should have access to mandatory pressure ulcer prevention training.

Staff will have access to relevant training and education in pressure ulcer prevention and management to include risk assessment, skin assessment, prescribing equipment, seating and positioning.

18. Monitoring and Auditing

18.1 Regular audits of an areas compliance and SSKIN Bundle will be undertaken across all areas involved in direct patient care.

19. Quick reference guide to pressure ulcer management

19.1 Patients should receive initial and on-going risk assessments using a combination of clinical judgement and the Waterlow Pressure Ulcer Risk Assessment Tool.

Pressure ulcer risk assessment should be completed within 4 hours of contact or admission. In the community initial assessment would take place at the first visit.

19.2 A full head to toe skin assessment should be carried out on all patients on admission to hospital or community case load.

Those who are identified at risk of developing pressure ulcers should have their assessment repeated monthly or if there are any changes in their condition.

19.3 If a patient has a pressure ulcer the wound must be assessed and this should be supported by photography and/or tracings with a ruler for calibration where appropriate.

19.4 The pressure ulcer grade should be recorded using the NPUAP/EPUAP Pressure Ulcer Classification System.

19.5 All patients deemed at risk of developing pressure ulcers should, as a minimum, be placed on a high specification foam mattress or Repose mattress if in ED.

19.6 Patients with a grade 1 or 2 pressure ulcer can be cared for on an appropriate high specification mattress dependent on the extrinsic and intrinsic factors presenting and ability to re-position themselves. They must be observed closely for any further signs of potential skin damage.

19.7 Patients with a grade 3 pressure ulcer should, as a minimum provision, be placed on a foam mattress or a critical alternating mattress and be repositioned as per policy.

19.8 Patients with a grade 4 pressure ulcer should be placed on an alternating pressure mattress replacement or continuous low pressure system and be repositioned as per policy.

19.9 All patients with pressure ulcers should actively mobilise change their position or be repositioned 4 hourly as a minimum standard.

19.10 All vulnerable patients identified as “at risk” should have an individualised pressure ulcer prevention care plan.
19.11 All pressure ulcers, on identification, must be recorded as a clinical incident using the appropriate incident reporting system.

19.12 Education of patient, carers and relatives and provision of written information about pressure ulcer prevention is an integral element of managing the patient’s condition. (NICE 2014).

20. References

Department of Health- Clinical Governance and Adult Safeguarding [2010]

European Pressure Ulcer Advisory panel [2014] Pressure Ulcer Treatment and Prevention, EPUAP.


21. Equality and Diversity

21.1 This document complies with the Torbay and South Devon NHS Foundation Trust Equality and Diversity statements.
Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

Ref No: 0208
Document title: Pressure Ulcer Prevention
Purpose of document: As stated
Date of issue: 20 May 2016 Next review date: 20 May 2018
Version: 6 Last review date: 10 April 2016
Author: Helen Orchard, Tissue Viability Nurse
Directorate: Organisation Wide
Equality Impact: The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief
Committee(s) approving the document: Jane Viner, Chief Nurse
Rob Dyer, Medical Director
Care and Clinical Policies Group
Date approved: 11 May 2016
Links or overlaps with other policies: All TSDFT Trust Strategies, policies and procedure documents

Does this document have training implications?  
If yes please state:
☐ ☐

Does this document have financial implications?  
If yes please state:
☐ ☐

Is this document a direct replacement for another?  
If yes please state which documents are being replaced:
☐ ☐

Document Amendment History

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<td>27 May 2010</td>
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<td>Equality Impact – Document Control Added</td>
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<td>10 April 2014</td>
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<td>6</td>
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<td>Jane Viner, Chief Nurse Rob Dyer, Medical Director Care &amp; Clinical Policies Group</td>
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The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions.

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.
Quality Impact Assessment (QIA)

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Does this document require a service redesign, or substantial amendments to an existing process? ☐

If you answer yes to this question, please complete a full Quality Impact Assessment.

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?

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<td>Gender re-assignment</td>
<td>Marriage and Civil Partnership</td>
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<tr>
<td>Pregnancy and maternity</td>
<td>Race, including nationality and ethnicity</td>
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<tr>
<td>Religion or Belief</td>
<td>Sex</td>
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<tr>
<td>Sexual orientation</td>
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If you answer yes to any of these strands, please complete a full Quality Impact Assessment.

If applicable, what action has been taken to mitigate any concerns?

<table>
<thead>
<tr>
<th>Who have you consulted with in the creation of this document?</th>
<th>Please select</th>
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<td>Patients / Service Users</td>
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<td>Trade Unions</td>
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<td>NHS Organisations</td>
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<td>Councils</td>
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<td>Staff</td>
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<td>Details (please state):</td>
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