

Pressure Ulcer Prevention and Management Policy

V10.1

August 2026

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Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

Before processing personal data, an appropriate Article 6 UK GDPR lawful basis must be identified and recorded. Where special category data is involved, a relevant Article 9 condition must also be documented.

All staff, contractors, students, volunteers, agency workers, and third parties working on behalf of the Trust are responsible for complying with data protection legislation.

Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

1. Introduction

- 1.1. Pressure ulcers are caused when sustained pressure, or pressure in combination with shear, is applied to the skin and/or underlying tissues. This is usually over a bony prominence or related to medical or other devices. The ulcer can present as intact skin or as an open ulcer, which may be painful. Pressure ulcers are largely a preventable harm but are estimated to cost the NHS up to £2.1 billion a year to treat (EPUAP 2019).
- 1.2. The National Institute of Clinical Excellence (NICE) and the European Pressure Ulcer Advisory Panel (EPUAP) have produced national and international guidance that can prevent or reduce the risk of pressure ulcer incidents. These recommendations include risk assessment of patients on admission, regular monitoring of skin condition and documentation, regular repositioning and management of risk factors related to the development of pressure ulcers.
- 1.3. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

- 2.1. The purpose of this policy is to standardise prevention and management strategies for pressure ulceration across the Trust in accordance with NICE and EPUAP guidance and best practice.
- 2.2. Implementation of this policy will:
 - Provide clinical staff with a clear set of standards of practice to deliver safe, effective patient care for the prevention and management of pressure ulcers.
 - Provide clinical staff guidance relating to risk assessment, pressure ulcer prevention practices, identification and categorisation of pressure damage and management of patients with pressure damage.
 - Create a safer hospital environment for patients across the Trust.

3. Scope

- 3.1. This policy applies to all professional groups employed within the Royal Cornwall Hospitals NHS Trust (RCHT) who have contact with patients who are at risk of developing or have existing pressure ulceration.
- 3.2. It will seek to provide a consistent quality approach to the prevention and management of pressure ulceration for all patients admitted to our care.
- 3.3. This policy should be read and used in conjunction with the local wound management guidelines and local wound care formulary.

4. Definitions/Glossary

- 4.1. Pressure ulcer - “A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), 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”. (NHS Improvement 2018).
- 4.2. MASD – Moisture Associated Skin Damage.
- 4.3. SDTI – Suspected Deep Tissue Injury.

5. Ownership and Responsibilities

5.1. Role of the Chief Nurse and Safety Committees

- To provide assurance to the Trust Board that processes are in place for reducing the risk of patients developing pressure ulcers and that these are effective.
- To review the pressure ulcer data for the Integrated Performance Report (IPR).

5.2. Role of Division Operations Directors/ Divisional Heads of Nursing

- Ensuring that the processes outlined in this policy are adhered to and that lessons learnt from investigations are implemented within their division.
- Utilising data provided from Trust reporting including the monthly Pressure ulcer report, quarterly reporting and the outcomes from PSIRF processes to observe for themes in relation to the quality of clinical records and effective care plans for the reduction of harm from pressure damage.

5.3. Role of the Clinical Matrons

- To be responsible for the implementation of this policy and for the reduction of pressure ulcers in their division.
- Utilising data provided from Trust reporting including the monthly Pressure ulcer report, quarterly reporting and the outcomes from PSIRF processes to observe for themes in relation to the quality of clinical records and effective care plans for the reduction of harm from pressure damage.
- Ensure staff can access appropriate training in relation to pressure ulcer prevention and management.

5.4. Role of the Ward Leaders

- Acting as the clinical lead and role model for pressure ulcer prevention and management within their ward/team/department.

- Have an open and honest culture and discuss current incidence rates of pressure ulceration.
- Ensure staff can access appropriate training in relation to pressure ulcer prevention and management.
- Undertake duty of candour with a patient who develops pressure damage that meets the moderate investigation criteria.
- Promote a culture of patient involvement in pressure ulcer prevention and treatment care planning.
- Review the monthly pressure ulcer report and lead on PSIRF investigations, observing for themes in relation to the quality of clinical documentation and care planning to create learning and action plans to reduce pressure ulcer harms.

5.5. Role of the Tissue Viability Service

- The Tissue Viability Service are responsible for developing and implementing clinical policies and guidelines following national and international guidance in the prevention and management of pressure ulceration.
- To monitor and review pressure ulcer reported incidents to ensure accurate validation of pressure ulceration.
- To complete the Pre-Pressure Ulcer PSR 1 Checklist (see [Appendix 3](#)) for all incidents reported as RCHT acquired category 3, 4 or unstageable to determine if these amount to a moderate harm incident. This also applies to multiple category 2 pressure ulcers acquired within the trust.
- To ensure learning from incidents is shared across the trust and within relevant incident review groups to inform practice improvement.
- To provide education and training in the form of study days, self-directed learning resources, toolboxes and practical workshops.

5.6. Role of Clinical Staff

- All clinical staff within RCHT have a responsibility and role in prevention of pressure ulcers.
- All clinical staff have a responsibility to adhere to this policy.
- All staff must ensure they have sufficient knowledge to be deemed competent in the prevention and management of pressure ulceration, in accordance with their role.
- All Nursing/Allied healthcare registered professionals have a duty to ensure all patients within their care are risk assessed within recommended time frames and patients identified as at risk of developing pressure ulceration have an individualised plan of care commenced.

- All Nursing/Allied healthcare registered professionals have a responsibility to ensure that the delegation of care to non-registered healthcare workers is appropriate.
- All clinical staff have a responsibility to ensure that patients are provided with evidence-based information to allow informed decision making and promote prevention of pressure ulceration.

6. Standards and Practice

6.1. Pressure ulcer risk assessment

- 6.1.1. All patients must have a pressure ulcer risk assessment completed within 6 hours of presenting to an admitting area. This should be documented on NerveCentre. The risk assessment can only be completed by a registered Nurse or registered Allied Health Professional. This must include a full skin inspection (see [Appendix 10](#) for admitting areas pathway).
- 6.1.2. Reassessment of pressure ulcer risk should take place weekly or when the patient's condition changes. Patients will be reassessed on admission to each new clinical area.
- 6.1.3. Please see [Appendix 4](#) for further information on risk factors and risk assessment

6.2. SSKIN bundle assessment

- 6.2.1. All patients should have a full skin assessment completed within 6 hours of presenting to an admitting area or transfer to an inpatient setting. This should be documented on the SSKIN bundle on NerveCentre. All clinical staff can complete the SSKIN bundle inspection if they have sufficient knowledge to do so.
 - If a patient has capacity and declines a full skin inspection, please ensure this is documented on the SSKIN bundle. A skin inspection should be offered as per the risk assessment, and the outcome should be documented on the SSKIN bundle at each assessment/offer of assessment.
- 6.2.2. **SSKIN bundles should be completed according to the outcome of the pressure ulcer risk assessment:**
 - No risk – An initial skin assessment should be completed on admission and then as required.
 - At risk – Once daily skin assessments, which should be documented on NerveCentre.
 - High risk – Twice daily skin assessments, which should be documented on NerveCentre.

- Very High risk – Three times daily skin assessments, which should be documented on NerveCentre.

6.2.3. A full skin assessment should include:

- Skin inspection in vulnerable areas over bony prominences, such as heels, sacrum, ischial tuberosities, elbows, shoulders, back of head and toes (see [Appendix 5](#)).
- Parts of the body in contact with anti-embolism stockings.
- Parts of the body where pressure, shear and friction are exerted during an individual's activities of daily living.
- Parts of the body where there are external forces exerted by a medical device i.e. Nasal cannula, catheters, oxygen masks, splints.
- Skin inspection must include the occipital area for neonates, infants, children and young people.
- When conducting a skin assessment in an individual with a darker skin tone, assessment of skin temperature, oedema and change in tissue consistency in relation to surrounding skin should be completed and documented. (see [Appendix 6](#)).

- 6.2.4. Patients with anti-embolism stocking in situ should have their stockings removed daily, regardless of their pressure ulcer risk assessment outcome. Patients who are independent should be encouraged to care for the stockings themselves.

6.3. Pressure relieving equipment

- 6.3.1. Support surfaces should be chosen on an individual basis depending on the needs of the patient. The use of any pressure relieving equipment does not replace the need for regular repositioning and skin inspection.
- 6.3.2. The following factors should be considered when selecting pressure relieving equipment:
- The patients pressure ulcer risk.
 - Level of mobility.
 - The patient's weight.
 - Patient preference.
- 6.3.3. Patients at very high risk should be moved onto a dynamic air mattress as soon as possible. They should have a high specification cushion in the chair if they are sitting out, as well as heel offloading (see equipment selection pathway).

- 6.3.4. Patients at high risk should be assessed using the above criteria as well as clinical judgement. If patients are better able to reposition on a foam mattress, therefore reducing their risk of pressure damage, this should be considered. A rationale for mattress choice in high-risk patients should be documented in the notes.
- 6.3.5. Patients at risk should be nursed on a foam mattress.
- 6.3.6. Patients at no risk should be nursed on a foam mattress.
- 6.3.7. All equipment can be obtained from the equipment library on extension 3049.
 - This equipment is for inpatient use only and should not be discharged with the patient (the exception to this is heel boots).

6.4. Care of patients nursed on trolleys

- 6.4.1. Patients nursed on trolleys should be assessed for pressure ulcer risk as soon as possible. As above, any patients assessed as very high risk should be moved to a bed with a dynamic mattress as soon as possible.
- 6.4.2. If a dynamic mattress is indicated and unavailable, a trolley topper should be placed as soon as possible. These must be available in all areas where trolleys are used.
- 6.4.3. Patients nursed on trolleys for extended periods should be closely monitored, due to the reduced pressure relieving capabilities of the trolley and difficulty in repositioning.

6.5. Categorisation of pressure ulcers

- 6.5.1. Pressure damage is categorised according to the depth and severity, as below.
 - **Category 1** – Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; it's colour may differ from the surrounding skin. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. The presence of a category 1 pressure ulcer may indicate the patient is at risk of developing further pressure damage.
 - **Category 2** – Partial thickness loss of dermis presenting as a shallow open ulcer with a pink wound bed, without slough. May also present as an intact or ruptured serum-filled blister.
 - **Category 3** – Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. The depth varies by anatomical location; category 3 ulcers can be shallow in areas with little or no subcutaneous fat (e.g. bridge of the nose, ear, occiput, malleolus). In contrast, category 3 pressure ulcers can be extremely deep in areas of significant adiposity.

- **Category 4** – Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present, but do not obscure the depth of the wound. There is often tunneling and undermining present. The depth of a category 4 ulcer varies by anatomical location.
- **Unstageable** – Full thickness skin and tissue loss in which the base of the ulcer is completely obscured by slough and/or eschar. Until enough slough and/or eschar is removed to expose the base of the wound, the category cannot be determined.
- **Suspected Deep Tissue Injury (SDTI)** – Purple or 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 initially present as tissue that is painful, firm, mushy, boggy, warmer or cooler compared to surrounding skin. Deep tissue injury may be difficult to detect in individuals with darker skin tones. Evolution into a deeper ulcer may be rapid even with optimal treatment.

6.5.2. Please note that skin tears, dressing trauma, dermatitis, wounds including leg ulcers, maceration or excoriation are not categorised. These should instead be documented as vulnerable skin on the SSKIN bundle.

6.5.3. Device related pressure injuries

- Device-related pressure injuries result from medical devices, equipment, furniture and everyday objects that have applied pressure to the skin, either as an unintended consequence of their therapeutic use, or inadvertently due to unintended skin-device contact.
- Pressure injuries resulting from devices generally conform to the pattern or shape of the device.
- The term 'device related' describes the etiology of the pressure injury rather than the severity or tissue loss. Device related pressure ulcers should still be categorised as above, but a (d) should be used when documenting.

6.5.4. Mucosal membrane pressure injuries

- Mucosal membrane pressure injuries are pressure ulcers of the moist membranes that line the respiratory, gastrointestinal and genitourinary tracts. Mucosal membrane pressure ulcers are primarily caused by medical devices exerting sustained pressure and shear forces on the mucosa.
- In the respiratory tract, (e.g. mouth, lips nasal passages etc.), pressure injuries are typically caused by ventilation or feeding tubes, and/or their securement devices.
- Gastrointestinal tract pressure injuries and pressure injuries of the genitourinary tract are primarily caused by feeding tubes or ostomy appliances and catheters.

- Mucosal pressure injuries are not categorised in the way that pressure injuries of the skin and underlying tissues are categorised. Where pressure is a significant factor in the etiology of the mucosal wound, it should still be considered a pressure injury; however, it is inappropriate to categorise as mucosal pressure injuries do not present in a typical way.

6.5.5. Moisture Associated Skin Damage (MASD)

- MASD is related to moisture causing skin break down rather than pressure (see MASD pathway).
- The presence of moisture and MASD increases the risk of pressure damage occurring, so it is important to assess if the underlying skin is blanching. If the skin is red or broken but blanching, this is not pressure damage. See the section below on reporting of pressure ulcer incidents for advice on whether this should be reported or not.
- MASD increases the risk of fungal infection. If there are signs of fungal infection, please take a swab and ensure appropriate treatment is prescribed.
- If there is MASD present but there is also non-blanching redness, this should be categorised as pressure according to the categories above and reported on Datix.

6.6. Reporting of pressure ulcer incidents

- 6.6.1. All patients with a new or existing category 2, 3, 4, unstageable or mucosal pressure damage and suspected deep tissue injuries must be reported as a clinical incident on the trust Datix reporting system. If a patient has more than one pressure ulcer, please report the category of the worst pressure ulcer. For multiple pressure ulcers, ensure each location and category is documented on the Datix report.
- 6.6.2. Moisture Associated Skin Damage (MASD) should be reported via Datix if located over a bony prominence or in the pelvic area (buttocks, sacrum, gluteal crease, ischial tuberosity). MASD in other areas should be monitored and documented on the SSKIN bundle only.
- 6.6.3. All patients admitted to the trust with existing pressure damage must be reported on the Datix reporting system as **no harm**.
- 6.6.4. All patients with new pressure damage (as above) acquired within RCHT must be reported on Datix as **minor harm**. This will then be reviewed by the Tissue Viability team and upgraded if required.
- 6.6.5. All category 3, 4 and unstageable pressure damage will be assessed using the Pre Pressure Ulcer PSR 1 Checklist by the Tissue Viability team to determine the harm level. All incidents deemed to have caused moderate harm will be subject to a PSR 1 investigation. This will be triggered by the Tissue Viability team via Patient Safety.

6.7. Safeguarding

- 6.7.1. All Datix reports where multiple areas of category 2 or above damage are reported will be considered for a safeguarding referral using the Adult Safeguarding Decision Tool (see [Appendix 12](#)).
- 6.7.2. If safeguarding is a concern when completing a Datix report, please ensure this is noted on the incident form.

6.8. Repositioning

6.8.1. Adult patients

- Encourage adults who have been assessed as being at risk of developing a pressure ulcer to change their position frequently, at least every 2 to 3 hours.
- Where possible, patients should be encouraged to reposition off any areas where there is already existing pressure damage.
- The use of a 30-degree tilt has been found to be beneficial. This can be achieved by using pillows to support patients.
- If patients are unable to reposition themselves, help should be offered to do so, using the appropriate equipment if required.
- The recommended repositioning frequency of 2 to 3 hours should not be extended without a documented rationale and discussion with the patient's medical team. If the patient has a current pressure ulcer, this should be discussed with the Tissue Viability team. For non-concordant patients, please see the relevant section below.

6.8.2. Neonates, Infants, Children and Young People

- Encourage children and young people who have been assessed as at risk of developing a pressure ulcer to reposition every 2 to 3 hours.
- Neonates, infants, children and young people who are unable to reposition themselves should be assisted to change position, using appropriate equipment if required.
- The frequency of repositioning required should be recorded on the patient's individual risk assessment.
- The recommended repositioning frequency of 2 to 3 hours should not be extended without a documented rationale and discussion with the patient's medical team. If the patient has a current pressure ulcer, this should be discussed with the Tissue Viability team. For non-concordant patients, please see the relevant section below.

6.9. Prevention and management of pressure ulcers in high-risk patient groups

6.9.1. Critically ill patients

- Pressure injury rates in critically ill patients; those cared for in an intensive care unit, are reported as one of the highest among hospitalised individuals. This is often due to the high level of disease/illness burden, hemodynamic instability requiring the use of vasopressor medications, poor tissue perfusion and oxygenation and the multiple risk factors these patients often have for the development of pressure damage.
- Additionally, some preventative interventions may be limited or even contraindicated.
- Because of these higher risks, patients within intensive care should have all interventions delivered for a very high-risk patient, however there are additional measures that should be taken (see [Appendix 7](#)).

6.9.2. Patients with spinal cord injury

- Patients with spinal cord injuries are at higher risk of developing pressure damage due to lack of sensation, reduced or no ability to reposition below the level of the spinal cord injury and reduced circulation to pressure areas.
- Due to the above risk factors, it is essential to have a robust offloading plan in place for patients with a spinal cord injury, as well as the correct equipment. (Please see spinal cord information sheet 1 on documents library).

6.9.3. Patients receiving end of life care

- Patients receiving end of life care are very high risk of developing pressure damage, due to the risk of organ failure related to the skin.
- Due to the higher risk of skin breakdown, it is important to establish goals of care with the patient and their families. These goals should be clearly documented in the patient's notes.
- The SSKIN bundle should still be completed as per the risk assessment, even if the patient declines. This should be documented on the SSKIN bundle as the reason why all vulnerable areas of skin have not been reviewed.

6.9.4. Patients with high BMI

- Patients with a high BMI are at higher risk of developing pressure damage. This patient group is often more at risk of shear and friction and have increased difficulty in redistributing pressure.

- Patients with a high BMI are more at risk of stress incontinence, increased sweating and heat/moisture trapping between the body and support surface (mattress or cushion). This leads to an increased risk of both MASD and pressure damage.
- Obesity can also affect tissue perfusion as the risk of breathing difficulties is higher in this patient group.
- The above risk factors should be considered when implementing a pressure ulcer prevention care plan and selecting equipment for patients with a high BMI.
- Specialist bariatric beds are available from the equipment library, these come with an alternating air mattress as standard. These beds have an automated tilt and turn function which will tilt the patient from side to side at specific intervals. Further training on this function can be given by equipment library staff when required.

6.9.5. Neonates and children

- Neonates and children are at increased risk of pressure damage and should be assessed with the Braden Q risk assessment tool.
- A full skin assessment should include the occiput, as there is a higher risk of pressure damage to this area for children and neonates.
- Skin maturity, perfusion, oxygenation, and the presence of a medical device should be considered when assessing the risk of pressure injury in neonates and children.
- Paediatric patients who develop pressure damage should be referred to the Tissue Viability service for face-to-face review.

6.9.6. Patients within operating theatres

- Patients within operating theatres are at higher risk of developing pressure damage due to prolonged periods of immobility, potentially without the ability to reposition.
- Patients who are expected to be in the operating theatre for more than 3 hours should be assessed carefully pre and post procedure and if appropriate, suitable positioning equipment should be used. (see [Appendix 8](#) and [Appendix 9](#)).

6.9.7. Patients with medical devices in situ

- Patients with a medical device in situ are at higher risk of developing a pressure ulcer. Each device fitted should be assessed for design and material, correct sizing/shape for the individual and the ability to be correctly applied and secured.
- Patients with neck collars should be given daily collar care by the Occupational Therapy team to reduce the risk of pressure damage.

- All medical devices should be checked at least once daily for early signs of skin, tissue and mucous membrane injury. This assessment should include checks underneath and around medical devices and their securements.
- Medical devices should be removed as soon as clinically appropriate to reduce the risk of pressure damage.
- If devices must remain in situ for clinical reasons, they should be regularly repositioned as appropriate. Support systems should be used where available and the type of device should be alternated if available and clinically appropriate.
- Appropriate dressings should be used under clinical devices to protect the skin, where the dressing will not interfere with the device placement.

6.10. Patient Information

- 6.10.1. Patients who are at risk of pressure damage should be provided with a patient information leaflet, in the format that is most suitable for the needs of the patient.
- 6.10.2. Duty of candour – patients and/or carers must be informed of the development of pressure damage and this conversation must be recorded in nursing documentation.

6.11. Managing and recording patient non-concordance

- 6.11.1. If patient concordance with pressure ulcer prevention is poor, the following actions must be taken (see [Appendix 11](#) for pathway).
 - The risks associated with poor concordance and the impact of pressure ulcers if they develop must be explained to the patient and the conversation must be documented in the patient's notes.
 - If possible, the care plan should be adjusted so it is mutually acceptable, ensuring the patient understands any increase in risk as a result of changing the care plan.
 - All resources should be utilised to decrease the risk to the patient including family/carer support.
 - All non-concordance that places the patient at increased risk must be escalated to the clinician with overall responsibility for the patients care as soon as reasonable possible.
 - If the patient has mental capacity and chooses to be non-concordant despite all reasonable adjustments, the plan of care should be adjusted accordingly and re-evaluated at least weekly. Consider self-neglect and if a safeguarding referral is required.

6.12. The use of prophylactic dressings

Prophylactic dressings should not be used unless specifically advised by the Tissue Viability Service.

7. Dissemination and Implementation

- 7.1. This policy once approved will be stored on the Trust documents library on the intranet. Significant updates will be communicated to all staff via Trust communications.
- 7.2. Implementation of this policy will be via Trust wide communication and supported by appropriate training for relevant members of staff.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Incidence reporting
Lead	Jasmine Conlon - Tissue Viability Clinical Nurse Specialist
Tool	Incident reporting system. Audit data.
Frequency	Monthly monitoring with quarterly reporting.
Reporting arrangements	Report sent to divisional managers, senior leadership, matrons, ward managers and charge nurses. Results reported in Board Integrated Performance Review Report and discussed at Board level.
Acting on recommendations and Lead(s)	Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes? Required actions will be identified and completed in a specified timeframe. Consider stating this responsibility in committee terms of reference.
Change in practice and lessons to be shared	Designated leads will forward where appropriate the lessons to be learned with all relevant stakeholders.

9. Updating and Review

- 9.1. The document review process is managed via the document library. Document review will be every three years unless best practice dictates otherwise. The author remains responsible for policy document review. Should they no longer work in the organisation or in the relevant practice area, an appropriate practitioner will be nominated to undertake the document review by the designated director.
- 9.2. Revision activity will be recorded in the versions control table to ensure robust document control measures are maintained.

10. Equality and Diversity

- 10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

10.2. Quality and Equality Impact Assessment (QEIA)

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged. The Quality and Equality Impact Assessment (QEIA) Form is available via the link in [Appendix 2](#).

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Pressure Ulcer Prevention and Management Policy V10.1
This document replaces (exact title of previous version):	Pressure Ulcer Prevention and Management Policy V10.0
Date Issued/Approved:	11 June 2026
Date Valid From:	August 2026
Date Valid To:	July 2029
Author/Owner:	Jasmine Conlon, Tissue Viability Clinical Nurse Specialist
Contact details:	Tissue Viability Team – 01872252673. rcht.tissueviability@nhs.net
Brief summary of contents:	This policy sets out the framework to guide evidence-based care in the prevention and management of pressure ulcers.
Suggested Keywords:	Ulcer, pressure, category, tissue viability, repositioning, equipment
Target Audience:	RCHT: Yes CFT: No CIOB ICB: Yes
Executive Director responsible for Policy:	Dual Chief Nursing Officer
Approval route for consultation and ratification:	Clinical Cabinet
Manager confirming approval processes:	Ian Moyle-Browning, Associate Director of Nursing
Name of Governance Lead confirming consultation and ratification:	Director of Nursing Midwifery and Allied Health Professionals at RCHT
Links to key external standards:	CQC Outcome 4

Information Category	Detailed Information
Related Documents:	• Tissue Viability Referral Pathway. • NICE Guidance Prevention and Treatment of Pressure Ulcers CG179. • NHSI Pressure ulcers: revised definition and measurement 2018. NHS Improvement (2018) Pressure Ulcers: revised definition and measurement. NHS England. London. NPUAP/ EPUAP/PPPIA (2014) Prevention and Treatment of Pressure ulcers. Australia. NICE (2014) CG179 Pressure ulcer prevention and management. NICE. London NPUAP/EPUAP/PPPIA (2026) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline.
Training Need Identified:	Ongoing training as part of the TV education provision
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Corporate Clinical

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
20February 2013	V4.0	Previous changes not known.	Name and Job Title
20 February 2013	V5.0	Addition of preventative flow chart and update of SOP to reflect data collection processes. Changes to time frame for risk assessment from 6 hours to 4 hours.	Heather Newton, Tissue Viability Nurse Consultant
26 August 2014	V5.1	Mobile summary linked at appendix 1. No other changes.	Heather Newton, Tissue Viability Nurse Consultant
08 July 2016	V6	Updated category of pressure ulcers to include deep tissue injury and unstageable.	Heather Newton, Tissue Viability Nurse Consultant

Date	Version Number	Summary of Changes	Changes Made by
		Addition of skin changes at life's end. Updated Cat 3 and 4 SI investigation process. References updated to 2014 guidance. Paediatric risk score updated to Braden score. Cat 2 RCA process added. Equipment selection chart updated. Link added for safeguarding referral. Updated RCA process. Lower limb pathway addition.	
15 March 2017	V7	Updated 6.80 Reporting of pressure ulcers to reflect the need for a Registered nurse to complete the Datix report. App 7 Data collection SOP and App 10 Pressure Ulcer RCA methodology also updated to reflect the changes mentioned above	Heather Newton, Tissue Viability Nurse Consultant
22 October 2018	V8	Policy updated to reflect new NHSI guidance on definitions and measurement. Sections updated include Section 4, 6.1, 6.2, 6.3, 6.4, 6.12, 6.14, 6.16. Appendix 2,3,4,5,6	Heather Newton, Tissue Viability Nurse Consultant
16 July 2019	V8.1	Updated the deep tissue section on page 15 because of new wording and process and also the safeguarding section on pages 22 and 23 as the new process has just been agreed. Add another Appendix to demonstrate the flow chart.	Heather Newton, Tissue Viability Nurse Consultant
11 July 2022	V8.1	Guidelines updated as document out of date. Changes made to incident review processes and SSKIN bundle completion. Sections checked with subject experts – End of Life, IPAC, OT's, Equipment library and community services. SOP for data collection and monitoring added as an appendix. Equipment for discharge section 6.14 updated.	Heather Newton, Tissue Viability Consultant Nurse
November	V9.0	No further changes since July 2022. Policy	Heather Newton,

Date	Version Number	Summary of Changes	Changes Made by
2022		has since been approved. Policy rechecked to ensure NICE guidance is integral to policy	Tissue Viability Nurse Consultant
01 May 2026	V10.0	Full policy update to reflect new EPUAP guidance and remove out of date advice. Updates to all sections of the document including appendix. Document title updated from Pressure Ulcer Prevention Policy to Pressure Ulcer Prevention and Management Policy.	Jasmine Conlon, Tissue Viability Clinical Nurse Specialist
August 2026	V10.1	Formatting amendments made to document and Appendices 7,8,10 and 11	Jasmine Conlon, Tissue Viability Clinical Nurse Specialist

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#).

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net

Appendix 3. Pre Pressure Ulcer PSR 1 Checklist

This PSR checklist uses the learning from patient safety events criteria to determine if a patient who has developed a pressure ulcer has come to moderate harm focusing on the patient impact rather than the category of pressure ulcer. If any questions are answered with a YES, a PSR 1 should be triggered.

Definition of Moderate Harm	Pressure ulcer specific impact	Yes	No
Putting the patient Impact at the center of the investigation.	Does the patient feel that the pressure ulcer will have a significant impact on their quality of life?		
The patient required further healthcare beyond a single GP, HCP, ED visit.	Has or will the patient require specialist intervention such as referral to a surgeon, plastic surgeon, referral for advice beyond that expected?		
The patient required treatment beyond dressing changes/ clinic visits or short courses of oral medication.	Has or will the patient require surgical debridement for their pressure ulcer? Did the patient require antibiotics to treat the pressure ulcer?		
The patient required less than 2 weeks extended inpatient care.	Was the patient's stay extended more than that of 2 weeks post development of the pressure ulcer. (This does not include extended stays for other reasons such as requiring community care).		
The pressure ulcer has limited the patients Independence but not for less than 6 months.	Is the patient unlikely to be able to undertake their normal activities because of their pressure ulcer. (This should not include reduced mobility for other reasons).		
The pressure ulcer has affected the success of treatment for existing health conditions but has not influenced life expectancy or accelerated disability.	Is the pressure ulcer likely to affect other treatments such as surgery to another body part, specific medications that cannot be used in patients with open wounds?		
Significant omissions in care considered to result in moderate harm for the patient.	Were there any significant omissions in care that contributed to the pressure ulcer? I.e. No risk assessment and no skin assessments.		

Appendix 4. aSSKING Framework as Per NWCSP Guidance

	Action	Best Practice Guidance
a	Assess risk	• Pressure ulcer risk assessment should only be undertaken by a registered practitioner e.g. Registered nurse or nursing associate. • Consider risk factors associated with compromised skin integrity. • Undertake risk assessment using the PURPOSE-T assessment on NerveCentre, or alternatively the Braden Q risk assessment for paediatric patients. • Consider safeguarding if appropriate and take action where required.
S	Skin assessment and skin care	• Complete a top to toe skin assessment, including under medical devices where safe to do so. • Consider colour, texture and temperature of the skin during assessment. • Communication with the patient is essential – ask them to identify any areas which are numb, painful, itchy or uncomfortable. • Consider risk factors and underlying medical conditions that may affect the integrity of the skin. • Keep the skin clean, dry and well hydrated. • Document any vulnerable skin on the SSKIN bundle assessment on NerveCentre.
S	Surface	• Undertake Safer Handling Risk Assessment on NerveCentre. • Use the equipment selection tool to ensure the patient has the appropriate equipment in place for their pressure ulcer risk level. • Ensure that all patients requiring a dynamic air mattress also have a high specification cushion in the chair if they are sitting out. • Ensure heels are appropriately offloaded, with consideration of falls risk if selecting heel offloading boots. • Consider the impact of support surfaces and equipment on the patient's ability to reposition and mobilise.

	Action	Best Practice Guidance
K	Keep moving	• Patients who are unable to reposition themselves should be assisted to reposition as per their risk assessment outcome. For patients at risk of pressure damage, this should be 2 to 3 hourly. • Ensure appropriate equipment is available to aid repositioning, where required. • Promote self-management of repositioning and early mobilisation for patients who can reposition and mobilise with minimal or no assistance.
I	Incontinence or increased moisture	• Identify the cause of moisture related skin damage i.e. Incontinence, sweat, saliva, stoma fluid, wound leakage. • Create a structured care plan to include skin cleansers and barrier products where required – refer to the management of MASD pathway for more information. • Ensure all interventions are clearly documented.
N	Nutrition	• Assess the patient's nutritional status using the MUST tool on NerveCentre. • Escalate to Dieticians if required for nutritional supplementation. • Ensure any dentures are in place and well fitting. • Support patients with oral care where required.
g	Give information	• Provide Pressure ulcer prevention information leaflet to patients and/or carers. • Ensure information is understood and given in the format most accessible for the patient and/or carer. • Escalate concerns of safeguarding, capacity and concordance if required.

Appendix 5. Pressure Areas Map of Bony Prominences

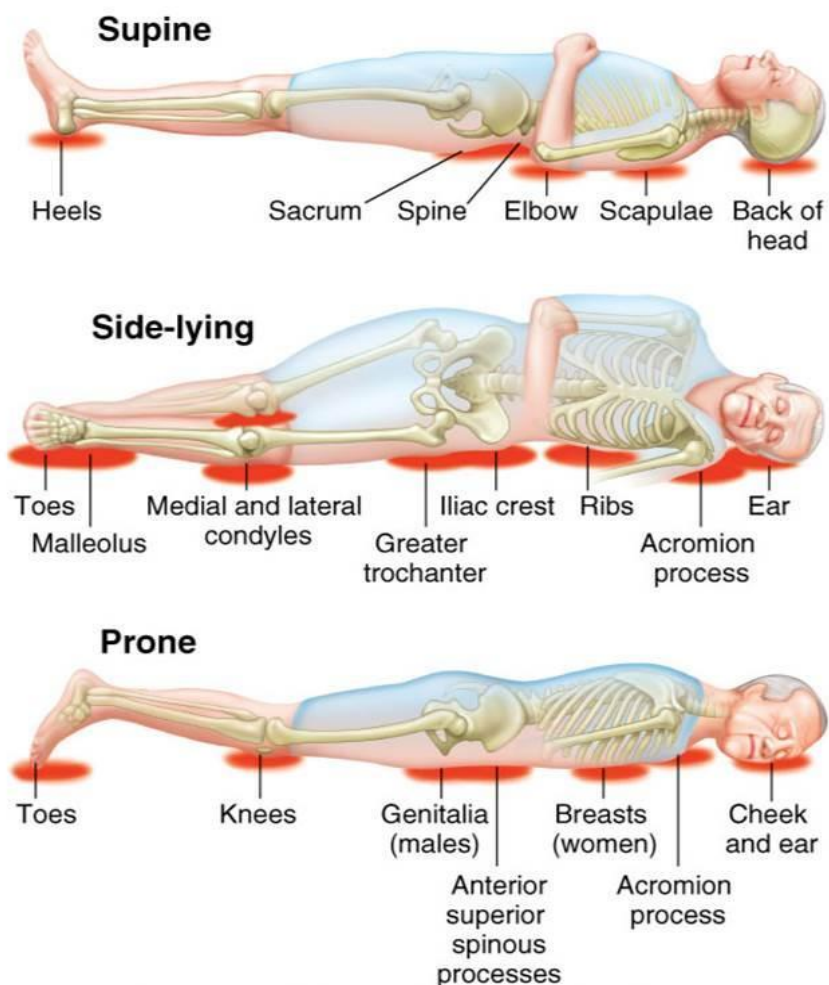


Fig. 33-2. Bony prominences subject to pressure, ischemia, necrosis, and ulceration in the supine, side-lying, and prone positions.

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Image provided from: "Harkreader H, Hogan MA, Thobaben M: Fundamentals of nursing: caring and clinical judgment, ed 3, St. Louis, 2007, Saunders".

Sitting

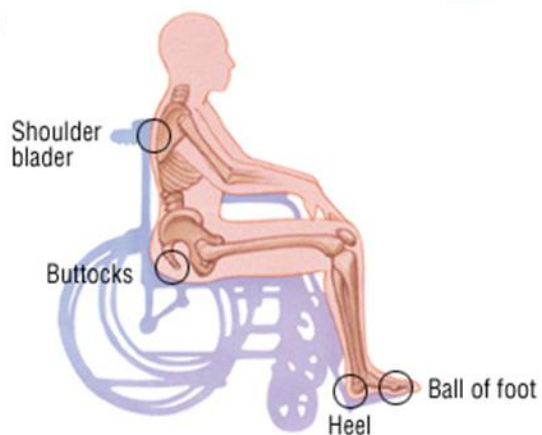


Image provided from: NHS providers for Patient information leaflets.

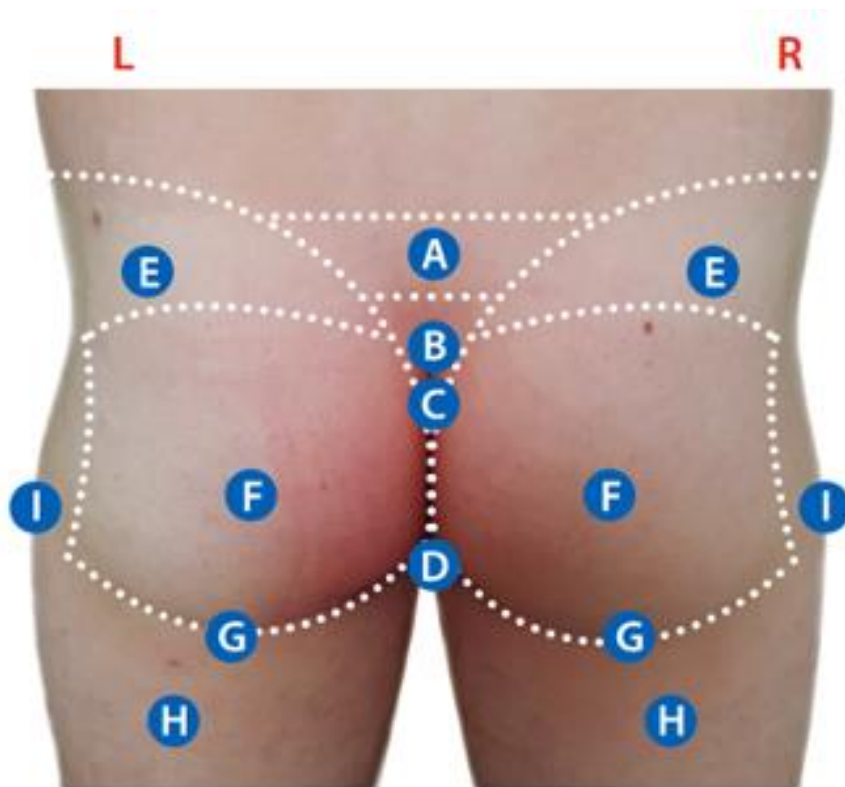


Image from: Journal of Wound Ostomy & Continence Nursing.

A – Sacrum

B – Coccyx

C – Gluteal Cleft

D – Perianal area

E – Sacral iliac crest

F – Buttocks

G – Ischial Tuberosity

H – Posterior thigh

I – Trochanter

Adapted from a diagram by Christine T Berke.

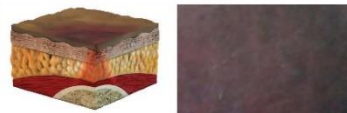
Appendix 6. Pressure Ulcer Assessment in People with Dark Skin Tones

Pressure Ulcers in People with Dark Skin Tones

PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR DARK SKIN TONES

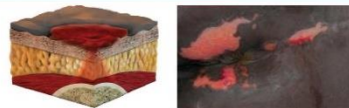
Category/Stage 1:

Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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 adjacent tissue. Stage 1 pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).



Category/Stage 2:

Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



Category/Stage 3:

Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.



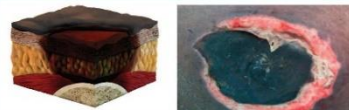
Category/Stage 4:

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.



Unstageable:

Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heel serves as 'the body's natural (biological) cover' and should not be removed.



Suspected Deep Tissue Injury:

Purple or 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 be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



A pressure ulcer (PU) can be defined as:

*"Localised damage to the skin and/or underlying tissue, as a result of pressure, or pressure in combination with shear. Pressure injuries/ulcers usually occur over a bony prominence but may also be related to a medical device or other object"*¹

Pressure ulcers are categorised by their severity and may be limited to the superficial tissues of the epidermis and dermis or extend to deeper tissue exposing and/or involving muscle, tendon and bone.

Early detection of pressure related skin damage is essential, as it allows for appropriate intervention which can prevent progression to more severe ulceration². Therefore, the ability to accurately identify and confirm Category 1 pressure ulcers in all skin types is of significant importance for clinical staff, carers and healthcare providers.

Health care professionals and carers are typically taught to look for redness (erythema) as a first sign of pressure damage and whilst this is relatively simple to identify in Caucasian skin it can prove to be difficult to diagnose accurately when assessing individuals with darker skin tones. It is likely that Category 1 PUs are under-reported in individuals with dark skin tone due to failure to identify early differences in skin colour as a result of pressure related tissue injury¹.

Skin pigmentation can mask the visual indication of erythema and Category 1 pressure ulcers are more likely to go undetected and deteriorate to full thickness pressure ulcers (Category 3 and 4) in darkly pigmented skin^{2,3}.

To reduce the risk of erythema (redness) and Category 1 pressure ulcers developing into full thickness wounds in patients with dark skin tones, it is essential for clinical staff and carers to recognise the other signs and symptoms than can be observed on the skin as early indicators of pressure related tissue injury^{4,5}.

REFERENCES

1. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Ulcer Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline 2019.
2. Springle S, Sheng L, Duckworth M. Detection of skin erythema in darkly pigmented skin using multispectral images. Adv Skin Wound Care. 2009;22(8):172-9.
3. Bennett A. Report of the task force on the implications for darkly pigmented intact skin in the prediction and prevention of pressure ulcers. Adv Wound Care. 1996;8(6):34-5.
4. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Ulcer Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Australia 2014.
5. Baker M. Detecting pressure damage in people with darkly pigmented skin. Wound Essentials. 2010;11(1):26-31.
6. Pan Pacific Pressure Injury Classification System for Dark Skin Tones. 2020. Pan Pacific Pressure Injury Alliance (PPPIA). Available online at <https://pppia.org/static/pdfs/pppia-classification-system-dark-skin-tones.pdf>. Accessed 21st September 2020.
7. MacGregor L, Calne S, Day K. International Review: Pressure ulcer prevention: Pressure, Shear, Friction and microclimate in context. A consensus document. Wounds International. 2010; London.

These important additional indicators of pressure related tissue injury to the skin include;

- Purple/bluish discoloration
- A purple hue where ischaemia is present
- Localised oedema/swelling due to the inflammatory response
- Temperature change – initial warmth due to the inflammatory response which will become cooler as tissue death occurs
- Pain and discomfort
- Alteration in sensation in response to either inflammation or ischaemia
- Change in tissue consistency in relation to surrounding tissue. For example, induration (hardness) due to excessive inflammation and necrosis. May also become soft and boggy.

Whilst these additional signs and symptoms are applicable to all skin tones, they can be particularly useful when caring for patients with dark skin tones when obvious pressure-related redness on the skin can be more difficult to identify.

CONSIDERATION FOR CLINICAL PRACTICE

Skin should be carefully inspected for any discoloration over pressure areas. Areas of discoloration in relation to surrounding skin should be assessed more closely for temperature changes, oedema, changes in tissue consistency and pain¹.

Note: This is a guide only, signs and symptoms of pressure ulcers may present differently on different skin tones. Education is a critical factor in ensuring that all members of the clinical team can strive to prevent and treat pressure ulcers according to the best evidence available¹.

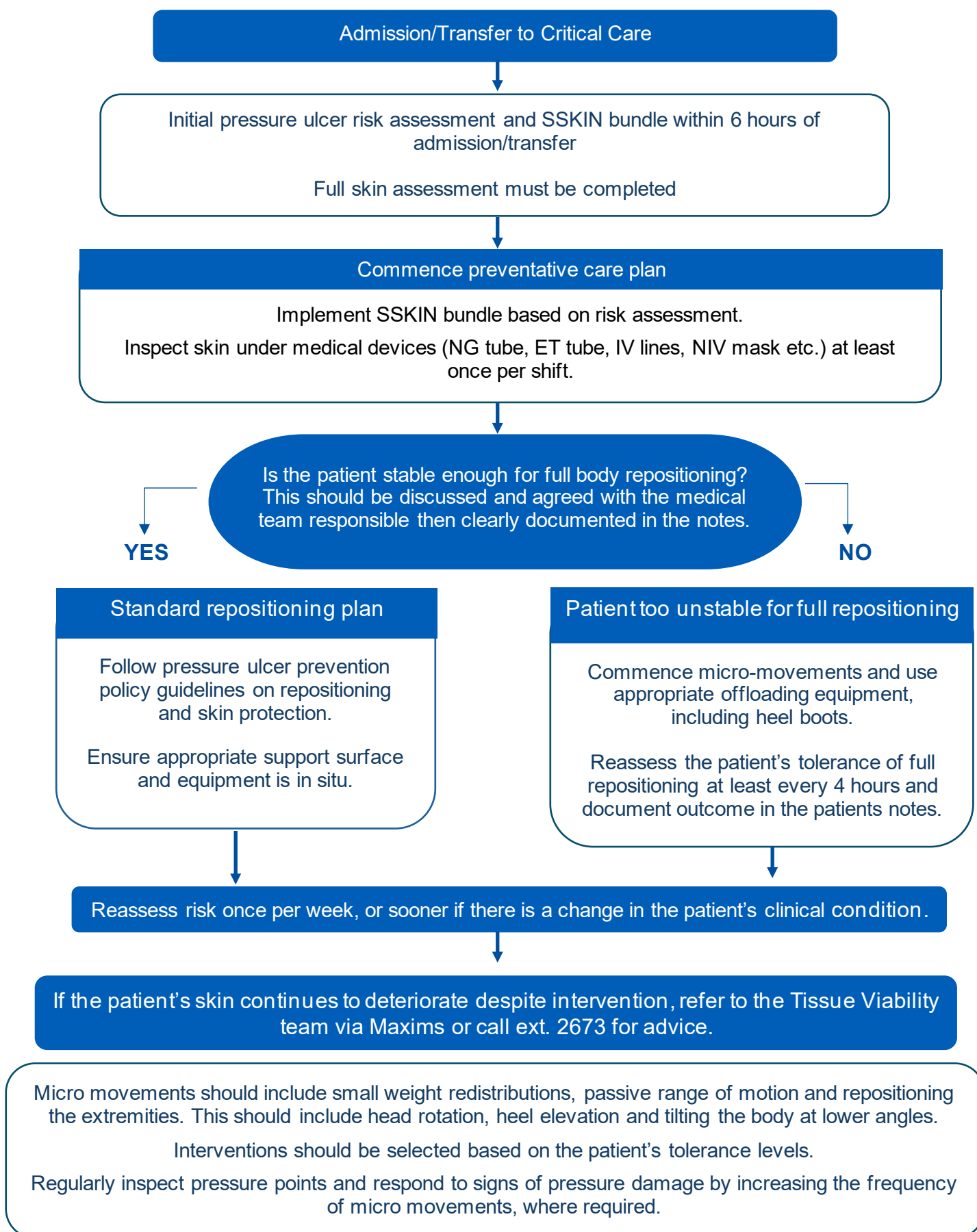


Text adapted from: International NPIAP/PPPIA Pressure Ulcer Classification System (2009,2014) published in National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA). Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014; Emily Heesler (Ed.) Cambridge Media: Chosone Park, WA. 3D graphics: Owned by ITVA. Photos: All photos courtesy Dr Kevyn Cebille, used with permission.

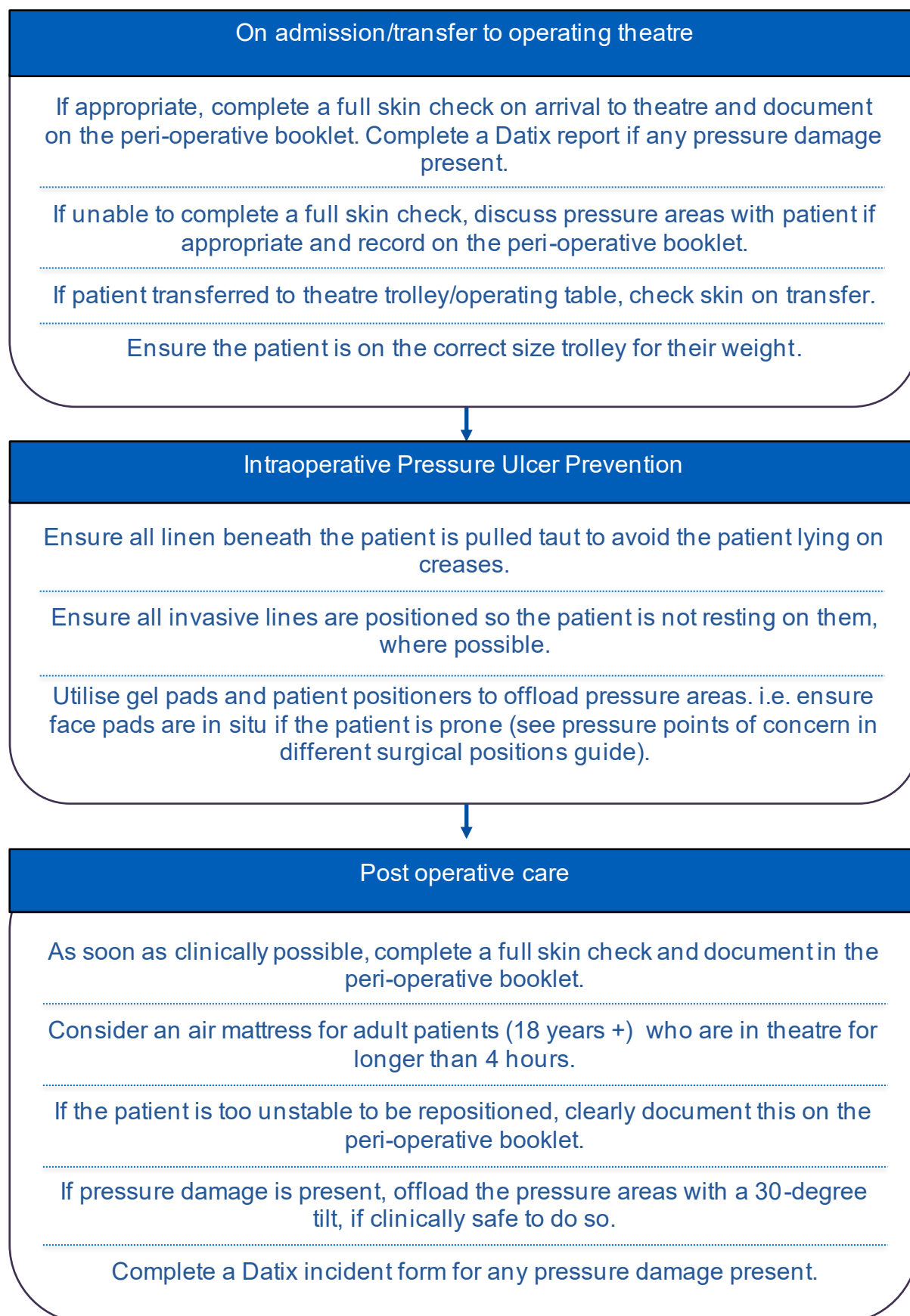
Remember...Prevention is better than cure!
#StopPressureUlcers #lovegreatskin #StopThePressure #aSSKING

#poweringPUprevention
WWW.DHG-HEALTHCARE.COM

Appendix 7. Pressure Ulcer Prevention Flowchart – Critically ill adults



Appendix 8. Pressure Ulcer Prevention Guidance–Operating Theatres



If the patient develops a new category 3+ pressure ulcer, refer to the Tissue Viability team via Maxims or call ext. 2673 for advice.

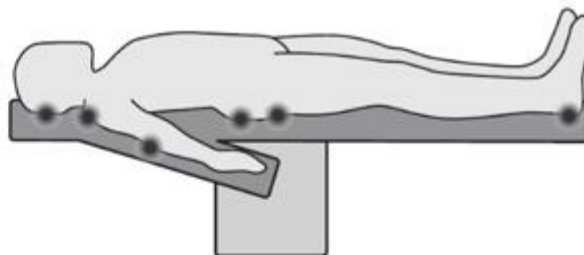
Appendix 9. Pressure Points of Concern in Different Surgical Positions Guide

Position and pressure points of specific concern

Supine

- Occiput
- Shoulder blade (scapula)
- Elbows
- Sacrum
- Coccyx
- Buttocks
- Heels

Illustrative position noting pressure points

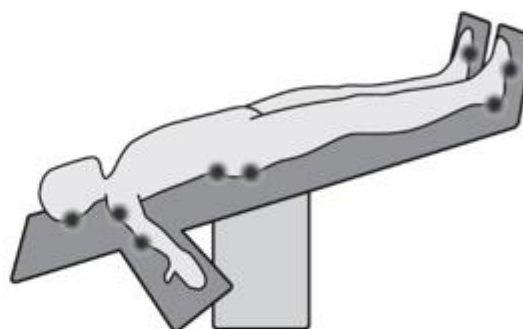


Trendelenburg

As per supine position

PLUS:

- Shoulders and scapula

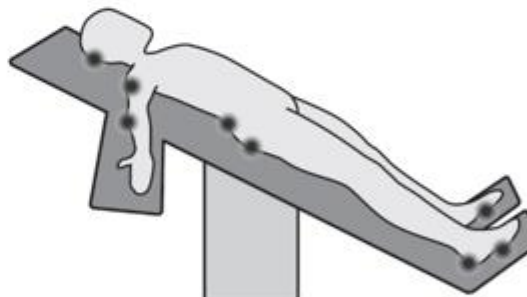


Reverse Trendelenburg

As per supine position

PLUS:

- Soles of the feet
- Shoulders and scapula



Sitting/modified sitting

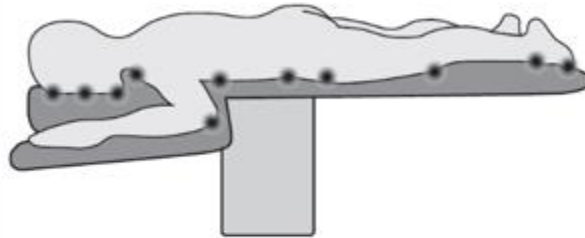
As per supine position BUT ESPECIALLY:

- Buttocks
- Ischium
- Coccyx
- Sacrum
- Back of knees
- Heels



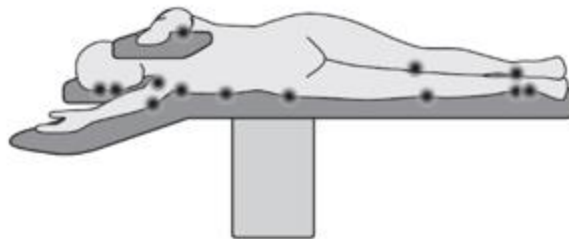
Prone

- Forehead
- Chin
- Cheeks
- Shoulder (anterior)
- Elbow
- Chest (breasts)
- Genitalia
- Anterior pelvic bones (iliac crests & ischium)
- Knees (patella)
- Dorsal feet and toes
- Nose (if positioned incorrectly)



Lateral

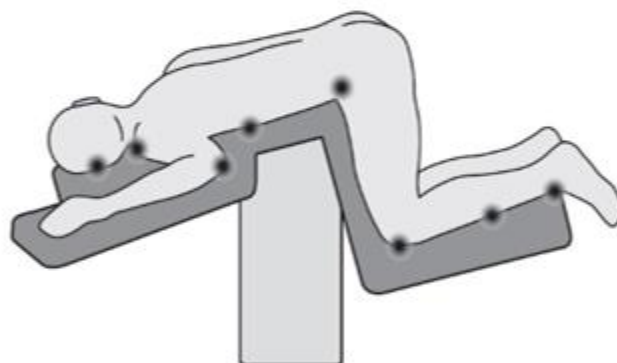
- Lateral face and ear
- Elbow
- Shoulder
- Axilla
- Superior and dependent arms
- Ribs
- Hips (trochanter)
- Malleoli
- Bent lower leg
- Knees
- Ankles



Kneeling position (knee/chest position)

As per prone position BUT ESPECIALLY:

- Face and ear
- Anterior chest
- Elbows
- Anterior pelvic bones (iliac crests and ischium)
- Knees
- Anterior tibia
- Anterior ankle

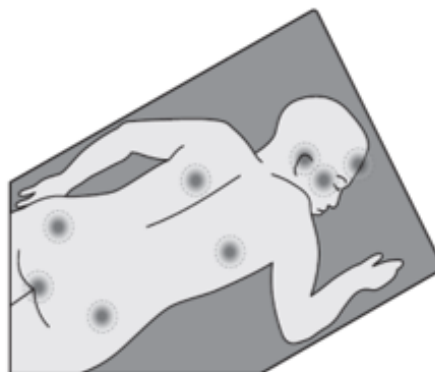


Freestyle/swimming position

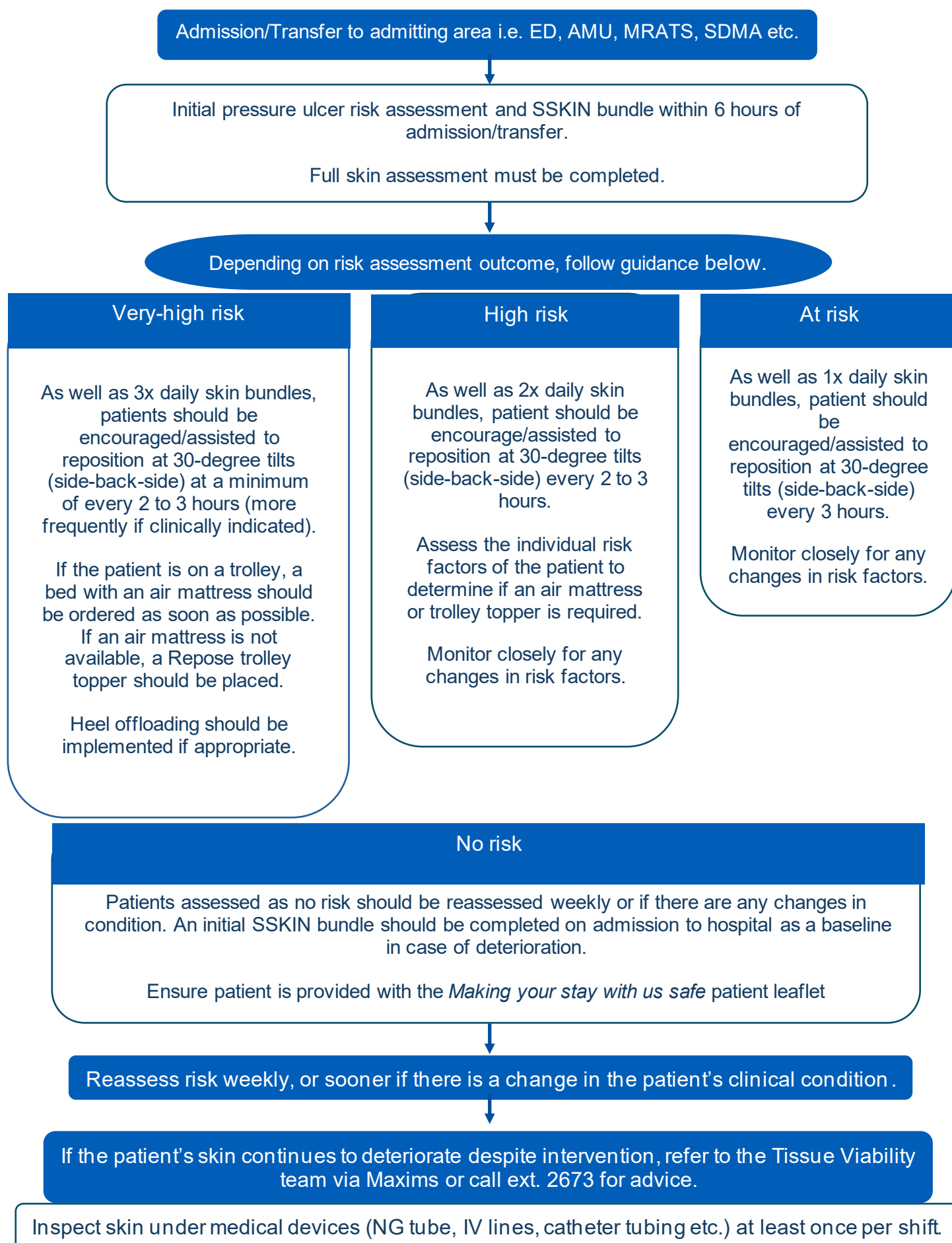
(Note: "Hidden" pressure points on the individual's underside are illustrated with dotted outlines)

As per prone position BUT ESPECIALLY:

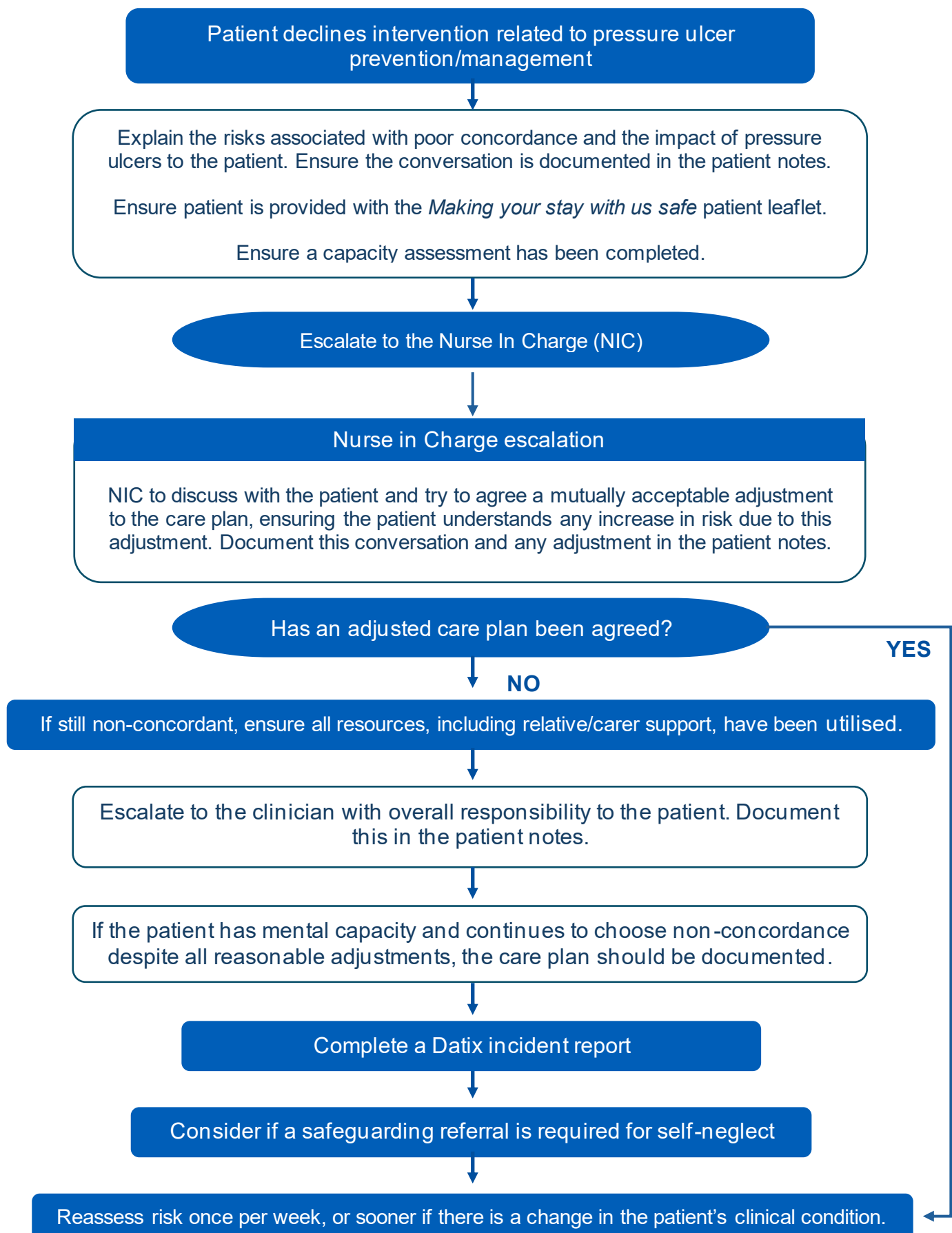
- Lateral face and ear



Appendix 10. Admitting Areas Pressure Ulcer Prevention Pathway



Appendix 11. Patient Non-Concordance Pathway – PU Prevention



Appendix 12. Adult Safeguarding Decision Tool for Patients with Pressure Ulcers

Adult Safeguarding Decision Tool for patients with pressure ulcers.

Name of assessing HCP (PRINT) : Date and time completed:.....

Name of patient : Patient NHS No:

Q	Risk category	Level of concern	Score	Evidence
1	Has the patients skin deteriorated to either a category 3, 4 , unstageable or multiple cat 2s from healthy unbroken skin , since the last opportunity to assess.	Yes : (skin has broken down)	5	
		No : (Present on admission)	0	
2	Has there been a recent change (days or hours) in their clinical condition that could have contributed to skin damage? ie infection, pyrexia, anaemia, Critical illness .	Change in condition contributing to skin damage	0	
		No change in condition that could contribute to skin damage	5	
3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? (in line with current policy)	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	0	
		Risk assessment carried out and care plan in place documented but not reviewed as persons needs changed.	5	
		No or incomplete risk assessment and /or care plan carried out.	15	
4	Is there a concern that the Pressure ulcer developed as a result the informal carer wilfully ignoring or preventing access to care of services.	No, not applicable or unknown	0	
		Yes	15	
5	Is the level of damage to skin inconsistent with the patient's pressure ulcer risk assessment? ie At risk however development of cat 3 or 4 pressure ulcer .	Skin damage less severe than the risk assessment suggests is proportional.	0	
		Skin damage more severe than the risk assessment suggests is proportional.	10	
6	Answer (a) if your patient has capacity to consent to every element of the care plan Answer (b) if your patient has been assessed as not having capacity to consent to any care plan or some capacity to consent to some but not all of the care plan.			
a	Was the patient compliant with the care plan having received information regarding the risk of noncompliance.	Patient not compliant with the care plan.	0	
		Patient compliant with some aspects of the care plan but not all	3	
		Patient compliant with care plan, but care plan is not suitable for the patients' needs / condition.	5	
b	Was the appropriate care plan in place reflecting the patient's best interest, following mental capacity act code of practice? (supported by documentation i.e. mental capacity assessment)	Documentation of mental capacity assessment and care plan undertaken in best interests.	0	
		No documentation of care being undertaken in patient's best interest.	10	
	Total score			

If score is 15 or more (or if you have any concerns) to be escalated to the safeguarding team. Adult Safeguarding decision Tool for patients with pressure ulcers to be uploaded to Maxims and Datix (to the incident report.)