Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

Pressure Ulcer Prevention and Management Policy

POLICY

Reference	CPG-TW-PUP&MP		
Approving Body	Clinical Outcomes and Effective Care Surgery Clinical Governance Group		
Date Approved	Aug-2025		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	30-Sept-2025		
Version	V5.0		
Summary of Changes from Version	Changes made to policy in line with: • National changes to pressure ulcer categorisation and reporting - Page 5 • Investigation of hospital acquired pressure ulcers in line with PSIRF - Page 15 • National guidance on the safeguarding of patients with pressure ulcers – Page 16		
Supersedes	V4.0 issued Oct 2021 – May 2025		
Document Category	• Clinical		
Consultation Undertaken	• Clinical Outcomes and Effective Care • Division of Surgery Clinical Governance group.		
Date of Completion of Equality Impact Assessment	November 2025		
Date of Environmental Impact Assessment (if applicable)	Not Applicable		
Legal and/or Accreditation Implications	No legal requirements to have this policy but provided to promote consistent high level safe care for patients and to prevent harm. Also based on national/ NICE guidance recommendations.		
Target Audience	Trust-wide		
Review Date	May 2025 (ext 2)		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	Stephanie Anstess – Nurse Consultant Tissue Viability		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Nursing/ Tissue Viability Team		

Position of Person able to provide Further Guidance/Information	Tissue Viability Nurse Consultant Tissue Viability Lead Nurse

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
• Pressure Ulcer Prevention and Management Generic Guideline *(2021)* • Pressure Ulcer Prevention and Management in Maternity SOP (2023) • Pressure Ulcer Pathway (PUP) – including PURPOSE-T • Patient Safety Incident Response Policy (2023) Safeguarding adults' protocol: pressure ulcers and raising a safeguarding concern (2024) • Policy guidance on recording patient safety events and levels of harm (2024) • Photography and Video Recording Policy and Policy for Consent to Examination, Treatment and Care. - will be adhered to for taking wound photographs. *Throughout the document it states take photographs, all will be taken following verbal consent from the patient, or where the patient lacks capacity, then in the patient's best interest.* • Wound Management Policy (2022) • Wound Care Formulary Document (2022)	*Currently being updated* *Currently being updated* *Currently being updated*
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

Pressure Ulcers (PUs) have a substantial impact on the health-related quality of life of patients. Most are considered to be preventable and there is a clear link between pressure ulcers and vulnerable adults. There is also a significant impact of the financial burden on the health service, treating pressure damage costs the NHS more than £3.8 million every day (NHS England/Improvement, 2020). PU's remain in the 'top ten harms' in the NHS in England (Fletcher 2022).

The Pressure Ulcer Recommendations and Clinical Pathway (The National Wound Care Strategy Programme 2024) commissioned by NHS England provide fundamental evidence-informed advice to healthcare practitioners for people who are at risk or have a PU. These are based on recommendations in the National Institute for Health and Clinical Excellence (NICE) Clinical Guideline: Pressure ulcers: prevention and management (NICE 2014) and the NICE Quality Standard: Pressure ulcers (2015) updated using the EPUAP, NPIAP, PPPIA Pressure Ulcer Guidelines (2019).

NICE (2014; 2015) identify that healthcare organisations should have an integrated approach to the management of PUs, with a clear strategy which is supported by senior management. Care should be delivered in a context of continuous quality improvements where improvements are the subject of regular feedback and audit within the clinical governance framework.

2.0 POLICY STATEMENT

The purpose of this policy is to provide staff within the Sherwood Forest Hospitals NHS Foundation Trust, standards, requirements and processes for effective pressure ulcer prevention and management.

The Primary and Secondary Pressure Ulcer Pathway Tool (Nixon et al 2015) is evidence based and provides the standards, requirements and processes based in this policy. This policy also describes the reporting and accountability framework for Pressure Area Management within Sherwood Forest Hospitals NHS Foundation Trust.

This clinical document applies to:

Staff group(s)

- All registered and non–registered clinical staff (Including AHPs) involved in providing care for patients at risk of or who have existing PU's.
- Non-clinical staff e.g. The Mattress Team, Medirest, Medical Equipment Management Department, Clinical Illustration etc.

Clinical area(s)

- All clinical areas, both in and out-patients across the Trust, where patients may be at risk of PUs or at risk of existing PUs deteriorating. This includes all ward and departments including the Emergency Department (ED), fracture clinic, theatres, X- ray, cardiac catheter suite, discharge lounge, Kings Mill Treatment Centre, Welcome Treatment Centre etc.
- All hospital sites – King's Mill Hospital, Newark Hospital and Mansfield Community Hospital.
- Clinical teams should work in conjunction with external clinical providers on Trust sites, for example the Renal Unit.

Patient group(s)

- All patients across the Trust who are at risk of developing PUs or have existing pressure damage.
- For additional specific advice for Maternity and Paediatrics, please see the Standard Operating Procedures within the appendices.

Exclusions

- Patients may be at risk within all patient groups, therefore there are no exclusions.

3.0 DEFINITIONS/ ABBREVIATIONS

3.1 Definitions

AHP's	Allied Health Professionals
HCP	Health Care Professional
NC	Nerve Centre
NWCSP	National Wound Care Strategy Programme
PU	Pressure Ulcer
PUR	Pressure Ulcer Review
PUP	Pressure Ulcer Pathway
PURPOSE-T	Pressure Ulcer Risk Primary or Secondary Evaluation Tool
RM	Registered Midwife
RN	Registered Nurse
Staff	All employees of the Trust including those managed by a third party organisation on behalf of the Trust.
STVN	Support Tissue Viability Nurse
The Trust	The Sherwood Forest Hospitals NHS Foundation Trust i.e. Kings Mill Hospital, Mansfield Community Hospital and Newark Hospital.
TVLN	Tissue Viability Lead Nurse
TVN	Tissue Viability Nurse
TVNC	Tissue Viability Nurse Consultant
TVT	Tissue Viability Team
WCP	Wound Care Pathway

3.2 Definition of a Pressure Ulcer

A pressure ulcer is an area of localised damage to the skin and /or underlying tissue, as a result of pressure or pressure in combination with shear. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object. The damage can be present as intact skin or an open ulcer and may be painful. (European Pressure Ulcer Advisory Panel and National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance 2019)

3.3 Diagnosis and Definition - PU's should be categorised using the following Categories

Category 1: Non blanchable Erythema The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin tones, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss. The patient may report pain or discomfort over the area.		
Category 2: Partial Thickness Skin Loss Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and or dermis.		
Category 3: Full Thickness Skin Loss Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue. Undermining and tunnelling may occur, fascia, muscle, tendon, ligament, cartilage and or bone are not exposed.		
Category 4: Full Thickness Tissue Loss Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage and or bone in the ulcer. There is an increased risk of osteomyelitis.		
Mucosal Pressure Ulcer: Mucosal membrane pressure ulcers occur in of the moist membranes that line the respiratory, gastrointestinal, and genitourinary tracts. They do not have the same anatomical structures as the skin therefore it is not possible to categorise them. They should be recorded only as Mucosal Pressure Ulcer without the allocation of a category.		
Medical device related PU's	PU's that occur from the use of a device designed and applied for diagnostic or therapeutic purposes.	These are categorised 1-4 or mucosal

3.4 Evolving Pressure Ulcers (PU's that cannot be categorised in the early stages)

The PU categories **'unstageable' and 'suspected deep tissue injury'** are no longer in use**.** Please use clinical judgment to categorise into category 1-4. (See PU guideline for more information)

3.5 Definition of a hospital acquired PU

A hospital acquired pressure ulcer is damage that occurs whilst the patient receives care from the Trust as an inpatient. An outpatient that develops a PU under a medical device (E.g. a cast or orthotic device) applied by the Trust should have an PU review before deciding if the PU was hospital acquired or not.

NHS improvement (2018) recommend that all pressure ulcers are investigated to support organisational learning and appropriate actions. Within the 'Patient Safety Incident Response Framework' hospital acquired PU's will be investigated appropriately

4.0 ROLES AND RESPONSIBILITIES

It is the role of the Trust Board to ensure that Pressure Area Management is a core element of the organisation's Patient Safety and Quality Board, and that appropriate equipment is available within the Trust. All employees working in clinical areas have an individual responsibility to maintain knowledge of the basic principles of pressure ulcer prevention and treatment and adhere to the pressure area management policy.

4.1 Nominated leads for pressure ulcer prevention and treatment:

4.2 Chief Nurse

- Has overall responsibility for ensuring that the Trust has clear processes for managing risks associated with the prevention and management of PUs.
- Ensures that appropriate arrangements to enable safe and effective care and that employees are fully aware of their statutory, organisational and professional responsibilities and that these are fulfilled.

4.3 Deputy Chief Nurse (Director of Nursing)

- Is responsible for providing senior management support and day to day leadership for the prevention and management of PUs within the organisation. The Deputy Chief Nurse (DCN) will agree threshold levels of hospital acquired PU's per division and ensure that senior management receive regular information and reports to inform decision-making and to provide assurance that this policy is being implemented across the organisation. The DCN will request a thematic review and assurance from Deputy Directors of Nursing and the TVT where threshold numbers are breached.

4.4 Tissue Viability Nurse Consultant/Tissue Viability Lead Nurse

- has trust-wide responsibility for the development of evidence-based strategies and policies for the prevention and treatment of PUs.
- is responsible for the provision of expert advice regarding pressure ulcer prevention and treatment.

- will provide an overview role in the PU review investigation process for all hospital acquired pressure ulcers (excluding category 1 pressure damage) in line with the Trust's Incident Reporting Policy.
- will produce an analysis of themes and trends of hospital acquired PUs and plan appropriate actions / strategies to prevent future harm.
- will support a robust system with a clear audit trail for validating and recording pressure ulcer data.
- will maintain and monitor the PU tracker and liaise with ward and department leads to ensure that actions are evidenced to provide assurance in relation to learning from incidents.
- will complete own actions from hospital acquired PU investigations and provide evidence onto the PU Governance Tracker.
- will confirm and challenge the PU review process for category 2 - 4 PU's alongside the Pressure Ulcer Review Panel Group.

4.5 Clinical Outcomes and Effective Care Group (COECG) will:

- ensure the pressure ulcer reduction plan remains a high priority on the quality agenda.
- monitor the pressure ulcer incidence data against internal thresholds and benchmark the Trust's performance monthly.
- monitor ward/division compliance with ward audits monthly.
- review themes and trends for hospital acquired PUs.
- provide assurance to the Trust that there is a process of continued improvement and shared learning.
- provide timely and proactive support to appropriate staff groups to ensure a reduction in PUs by sharing learning from incidents to prevent future harm.
- Report to the Nursing, Midwifery and Allied Health Professional Committee and the Board monthly as well as the to the Patient Safety committee quarterly which also report to the Board

4.6 The Tissue Viability Team (TVT) will:

- provide evidence based expert advice, education, and support to clinical staff
- monitor and validate all hospital acquired PUs across the trust
- monitor and validate patients admitted to the Trust with category 3 / 4 PU's or patients who admitted with a cluster of Category 2 PU's
- support an active tissue viability champion network
- monitor themes and trends from all hospital acquired pressure ulcers and plan appropriate actions. This will include education strategies to support learning from incidents in order to prevent future harm to patients
- complete own actions from hospital acquired PU investigations and provide evidence onto the PU Governance Tracker
- Assist with safeguarding screening when there is a suspicion of omission of care or neglect

All members of the TVT will be allocated individual wards or clinical areas to provide support in relation to pressure ulcer prevention, they will:

- Meet with the Ward/Department Lead and TV Champion regularly to understand the TV needs of the ward
- Monitor their named wards TV audit results
- Where possible be involved in PU reviews
- Agree action/support plans when required
- Escalate concerns to the TVLN

4.7 Matrons/Divisional Directors of Nursing will:

- ensure that the necessary management arrangements and structures are in place to support all employees to fulfil their obligations for pressure ulcer prevention and treatment
- be responsible for ensuring that this policy is implemented throughout their areas of management
- be required to ensure that Ward and Department Leads understand the expectations of them and are both competent and confident to implement the policy requirements
- monitor and investigate hospital acquired PU's within their area
- proactively monitor pressure area care outcomes and monitor the completion of action plans using the PU Governance Tracker.

4.8 Ward Leaders/ Department Leads will:

- be responsible for ensuring the staff in their services are aware and appropriately trained to deliver the standards within the policy
- perform PU audits on a routine basis e.g. a minimum of 5 patients' monthly
- monitor and investigate hospital acquired PU's within their area
- ensure staff under their management will have access to appropriate pressure relieving /reducing/off-loading equipment
- ensure improvements are made to services where deficiencies are identified through audit or monitoring processes
- identify staff who need further support and training and implement
- support and guide the TV Champions to deliver objectives within their area
- meet with the Support Tissue Viability Nurse (STVN) regularly to discuss progress and support requirements
- ensure medical staff are informed of new hospital acquired PUs and new patients admitted with deep PUs into their care
- complete own actions from hospital acquired PU investigations, and provide evidence onto the PU Governance Tracker to demonstrate assurance of actions and improvements / monitoring of care

4.9 Tissue Viability Champions will:

- complete the e-Learning for Health and study days for PU prevention and management
- support their colleagues with initial clinical advice and support teams to identify patients who meet the criteria for referral to the TV team.

- disseminate all relevant pressure ulcer prevention and treatment information to staff within their work area.
- with the support of the Ward/Department lead and Tissue Viability Nurses, they will ensure that all staff in their work environment are aware of and adhere to the Pressure Ulcer Prevention and Management Policies, Guidelines and Standard Operating Procedures
- meet with the STVN regularly to discuss progress and support requirements
- provide support to staff with the implementation of action plans from TV audit results, metrics or from hospital acquired PU investigation.

4.10 Nurse in charge will:

- ensure all staff permanent and temporary are aware of the PURPOSE-T assessment and planning care and effectively monitoring their patients
- be aware of patients deteriorating pressure areas and ensure this policy is followed

4.11 Registered Nurses/Midwives will:

- undertake the Trust's PURPOSE-T assessment on each patient within 6 hours of admission or transfer on Nerve Centre or the PUP
- complete skin assessment every 8 hours on patients at risk or who have PU's
- complete Datix and photographs within 24 hours of a PU developing
- implement an individualised prevention and management of PU care plan where appropriate, and follow it
- reassess patients' risk of PU's and change plan of care appropriately where pressure areas are deteriorating
- escalate pressure areas to the Nurse in Charge that are not responding to the care provided
- involve the relatives/carers of the patient where appropriate in the assessment and care planning
- complete training on e-Learning for Health and access TV study days
- take responsibility for their own knowledge and skills of PU's I.e. identify training needs and request study leave from Ward Leader

4.12 Registered Nursing Associates will:

- complete skin assessment every 8 hours on patients at risk or who have PU's
- complete Datix and photographs within 24 hours of a PU developing
- Implement an individualised prevention and management of PU's care plan where appropriate, and follow it
- reassess patients' risk of PU's and change plan of care appropriately where pressure areas are deteriorating
- escalate pressure areas to the Nurse in Charge that are not responding to the care provided
- involve the relatives/carers of the patient where appropriate in the assessment and care planning
- Complete training on e-learning for health and access TV study days

- take responsibility for their own knowledge and skills of PU's I.e. identify training needs and request study leave from Ward Leader

4.13 Student Nurse/Midwives and Health Care support Workers will:

- document accurately the skin evaluation on NC or the PUP chart
- take photographs of deteriorating pressure areas and escalate to the Nurse in Charge
- provide patient care as planned by the Registered Nurse
- take responsibility for their own knowledge and skills of PU's I.e. identify training needs and request study leave from Ward Leader

4.14 Allied Healthcare Professionals will:

- take responsibility for their own knowledge and skills of PU's I.e. identify training needs and request study leave from their line manager
- where AHPs regularly provide personal care, they will assess and record patients skin assessment
- AHP's will be aware of the 'Red flags' - section 6.2

4.15 Consultant Medical Staff will:

- be responsible for ensuring that their teams are aware of this policy and provide collaborative multi-disciplinary working to ensure the policy is adhered to
- regularly review the Category 3 and 4 PU's and non-healing PU's and the holistic wound management plan

This policy is relevant to all Sherwood Forest Hospitals NHS Foundation Trust staff and staff employed through other agencies working on a temporary basis providing care for patients with regards to pressure ulcer management and prevention.

5.0 APPROVAL

Following consultation, this policy has been approved by the Clinical Outcomes and Effective Care Group, and the Division of Surgery Clinical Governance group.

6.0 DOCUMENT REQUIREMENTS

6.1 Pressure Ulcer Risk Assessment

6.2 Red Flags: Assessment of PU risk and Immediate Care by health care professionals (HCP's) *without* pressure ulcer knowledge or skills e.g. radiology

Patients may be seen by a HCP who does not have the knowledge or skills in PU prevention and management but may be asked by a patient or a relative to give advice on the prevention or management of pressure ulcers. Where the HCP cannot seek immediate advice, the following

'red flag' risk factors and immediate care will guide the HCP to be able to identify risk factors or provide immediate care and seek further advice/management of PU's.

'Red flag' risk factors are:

- Skin over a bony prominence that is hot, discoloured and swollen or the patient complains of new onset or change / increase in pain or numbness, and this does not resolve when the patient is repositioned.
- An existing pressure ulcer or scar from a pressure ulcer or other wound in an at-risk area.
- The individual has had a long lie (fall and being on the floor) of more than 1 hour.
- Rapid deterioration in the clinical condition of the patient.
- There is a medical device in prolonged contact with the skin

HCP may need to provide immediate care without the assistance of a registered nurse or suitably trained clinician, which includes:

- Reposition the patient off the affected area and record the position in which the patient was found.
- If the skin is broken, clean and dress the wound using a sterile dressing as per local policy.
- Ensure any existing equipment is functioning and in use.
- Take a photograph of any broken skin or discoloured skin or request clinical photography.
- Seek assistance / escalate care / refer to specialist as necessary.
- Give patient, family and carers an advice sheet about what they can do to help manage the skin damage, including what they should avoid doing
- Document any interventions, conversations or care plans and ensure these are hand to other caregivers to ensure continuity.
- Check if medical devices in use are still required. If it is still, necessary fit and position correctly.

6.3 Assessment of PU risk by RN's and RM's

RN's and RM's across the Trust will use the pressure ulcer risk assessment tool: Pressure Ulcer Risk, Primary or Secondary Evaluation Tool (PURPOSE-T), for adult inpatients including maternity and should be completed within six hours of admission, transfer of care or deterioration of condition. The full PURPOSE-T can be found on Nerve Centre and in the Pressure Ulcer Pathway (PUP) document except maternity, where it can be found on Badgernet.

6.4 Pressure Ulcer Pathway

Following the assessment and using ***clinical judgment*** one of three pathways will be selected: Green, Amber or Red.

Pressure Ulcer Pathway

Green	No PU and not currently at risk	• Document outcome of risk in the clinical record. • Provide information to the patient and / or their carer about the level of risk and what they can do to help reduce the risk.
Amber	No PU or scarring from previous PU's, but at risk	As above *plus*: • Implement an individualised plan of preventative care that addresses their presenting risk factors and follows the aSSKINg bundle. (See Care planning 6.8, page 14) • Ensure there is regular monitoring of skin condition and escalate preventative care if any deterioration in skin condition is noted. • Document outcome of risk in the clinical record. • Provide information to the patient and / or their carer about the level of risk and what they can do to help reduce the risk.
Red	Existing PU or scarring from a previous PU	As above *plus*: • If deterioration in skin or wound is noted, escalate interventions including review of equipment (beds, mattresses, cushions and off-loading devices) and repositioning frequency. • Complete a full wound assessment and document in the care record. • Agree a patient-centred objective of care. Implement evidence-informed wound care based on the objective of care.

6.5 The GLAMORGAN ASSESSMENT TOOL is the pressure area risk assessment tool for paediatric patients, and should be completed within 6 hours of admission by the RN/RM. Note – The Paediatric PURPOSE-T will be piloted on Nerve Centre on Ward 25 Autumn 2025.

Glamorgan assessment tool can be obtained:

Within the Paediatric Early Warning Score	Paediatric Ward stationary supply	NA

6.6 PU Monitoring for patients

- The RN/RM will complete a skin assessment a minimum of every 8 hours and record on NC or the PUP. Photographs will be taken of skin damaged by pressure.
- A skin evaluation will also be completed and recorded as per care plan by a suitably trained health care provider and recorded on the PUP chart or on NC. Non-registered health care

providers will take a photograph and escalate any changes in skin condition immediately to the RN/RM.

- Skin assessments will be undertaken at least daily of pressure areas under and around dressings, bandages, plaster casts, bodily worn devices and skin traction and more frequently if risk is identified. The frequency of checks should be specified on the care plan, on NC or on the PUP.
- The RN/RM must take appropriate action as soon as possible when there is evidence of new pressure damage or deteriorating pressure damage, which will include:
    - Reassess the patient using PURPOSE-T (adults), Glamorgan (paediatrics)
    - Review the care plan and increase the repositioning/ upgrade the equipment
    - Discuss with the patient/family/carers
    - Keep the patient off the affected area
    - Escalate to the Nurse in Charge
    - RN/RM to monitor the pressure areas at each reposition until the pressure damage has resolved.
    - Where there is no improvement following review and change in care plan, and escalation and advise from Nurse in Charge refer to the Tissue Viability Team

6.7 Skin assessment is a vital step in assessing patient's risk of PU. However, they may be circumstances where it is not possible to complete, for e.g.

- the patient may decline
- it may not be possible
- it may be clinically inappropriate to

In these situations, the rationale must be documented on NC or the nursing/medical record. Where patients have declined skin assessment, when clinically required, record conversations with the patient and relatives to evidence concordance management. Ensure mental capacity assessments are completed where appropriate.

6.8 Care Planning

Plan and deliver individualised care that meets their presenting risk factors using the aSSKING Framework:

	Action
a	Assess risk
S	Skin assessment and skin care
S	Surface
K	Keep moving
I	Incontinence or increased moisture
g	Give information

See the Pressure Ulcer Prevention and Management Guideline for more details. This will include:

- Frequency of skin checks
- Repositioning requirements and frequency
- Skin care regime
- Pressure relieving equipment including, mattress, cushion/seating and heel off loading
- Nutrition
- Advice

6.9 Re-assessment

The pressure area risk (PURPOSE-T) or Glamorgan Tool (Paediatrics) should be re-assessed by RN/RM in the following circumstances:

- On internal transfer between wards/departments
- Following deterioration in pressure areas
- Following a significant change in the patients' overall condition (improvement or deterioration) e.g. a patient with new increase in National Early Warning Score, post-operatively or a patient who has returned to their usual baseline following a period of immobility.
- Or weekly (Amber/Red pathway)
- Daily (Green pathway)
- Weekly – Glamorgan Tool

The re-assessment, the care plan and equipment will be recorded on Nerve Centre or in the Pressure Ulcer Pathway (PUP) and will be updated as necessary.

6.10 In the event of an emergency where Nerve Centre fails, hard copies must be used.

Document Name	Document reference No.
Pressure Ulcer Pathway	002697
PURPOSE-T Screening Tool	FKIN 030109
Short Term Pressure Ulcer Pathway	FKIN 030336

6.11 REPORTING AND REFERRALS OF PUs

Categories 1-4 and mucosal PU's

- Report all PU's either from admission, transfer from another provider or on development within the Trust **within 24 hours on the Datix System.** Notification will be sent directly to the TVT for all hospital acquired PUs, and patients admitted with category 3 and 4. The TVT monitor the time taken to complete the Datix report, as late submission adds risk to the patient. Where staff have taken longer than 24 hours to report a HAPU, the PU review will include an action for learning.
- A photograph on NC must be taken on initial assessment or at the earliest opportunity, Referral to the Clinical Illustration department should also be made for professional photographs of category 3/4 and be taken within 24 working hours.
- If a patient develops multiple PU's by the same mechanism, then only one incident needs to be recorded (The worst category and level of harm). If two mechanisms are involved e.g. medical device and seating, then two incidents and levels of harms need to be completed.
- The TVT assess all hospital acquired PUs (1-4 and mucosal) within a maximum of two working days, and both hospital acquired and on admission category 3/4 PU's within one working day. The TVN will validate the diagnosis and the category of PU.

6.12 INVESTIGATION OF HOSPITAL ACQUIRED PUs

- A PU review of patients with hospital acquired category 2,3 4 and mucosal PU's will be completed by the Senior TVN, the Ward Leader, Matron (or Deputy) and staff involved, using the nursing and medical notes. Patients' and family will also be involved where appropriate. An action plan will be completed.

6.13 Category 2 PU's

- The PU review with any identified learning will be presented by the Ward Leader at the PU/ Skin Damage Panel, chaired by the Director of Nursing, with the Lead/Senior TVN, the Matron and Divisional Director of Nursing or Deputies. The action plan will be agreed with those in attendance and will be monitored for completion by the TVT.
- Learning and good practice is to be shared with the Harms Free Meeting and items escalated to the Nursing, Midwifery and Allied health Professionals Committee. The TVLN will monitor the themes and trends for analysis and appropriate action.

6.14 Category 3 and 4 PUs or multiple superficial PU's

- Potentially meets the Trusts Patient Safety Incident Response Plan (PSIRP), or the level of harm is potentially considered moderate or above a Rapid Review will be presented by the Ward Leader to the appropriate Divisional Rapid Review

meeting for discussion, attended by a member of the clinical team involved, a Senior TVN and a representative from the Governance Support Unit.

- Where the level of harm is considered low, investigation and reporting will follow that required for a category 2 PU.
- Where the level of physical or psychological harm is reported as at least moderate, the Duty the Candour policy needs to be followed
- If the Divisional Rapid Review meeting panel agree that escalation or further investigation is required, the Rapid Review will be presented to the Patient Safety Incident Response Group (PSIRG) for discussion. Should the pressure damage trigger a Patient Safety Incident Investigation (PSII) this will be reported on Strategic Executive Information System (STEIS).

6.15 Reporting levels of harm

The PU Review Team will agree the level of harm for category 2 PU's. For category 3 and 4 PU's or cluster of Category 2 PU's that are presented to the Divisional or Trust Rapid Review meeting, the level of harm will be agreed in line with National guidance (2024). In addition, The Tissue Viability Society 2012 advises the criteria for serious harm are PUs that result in:

- Loss of limb
- Loss of life
- Requiring surgery for the PU e.g. debridement, reconstruction
- Cluster of PUs in a clinical area
- At the provider organisation discretion

6.16 Unreported PU's

Where a patient has been discharged or transferred with an unreported deep PU the Trust TVT will be alerted by the new provider for investigation. The TVT will confirm and challenge the alert with the new provider. Where it is agreed the deep PU developed within the Trust the process for investing a hospital acquired PU category 3 or 4 PU will be followed.

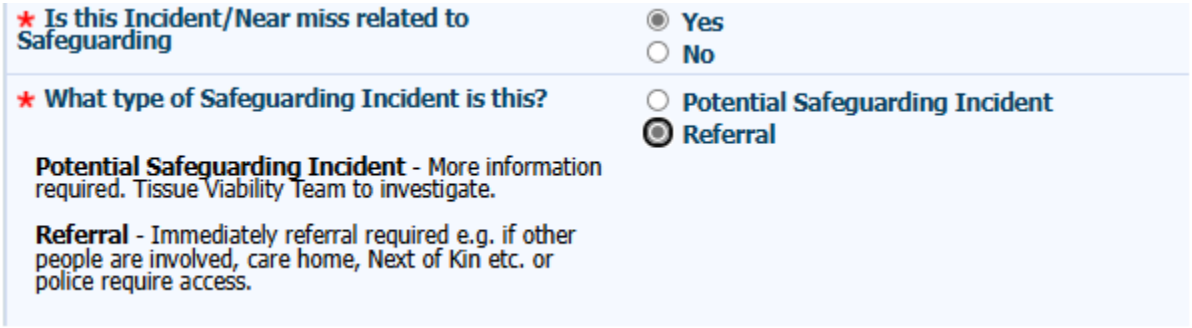
6.17 Safeguarding Patients with PU's

Patients admitted with or patients who develop in hospital category 3/4 PU's or a cluster of category 2 PU's need to be assessed for any evidence of omission of care or neglect. To avoid inappropriate MASH referrals, consider:

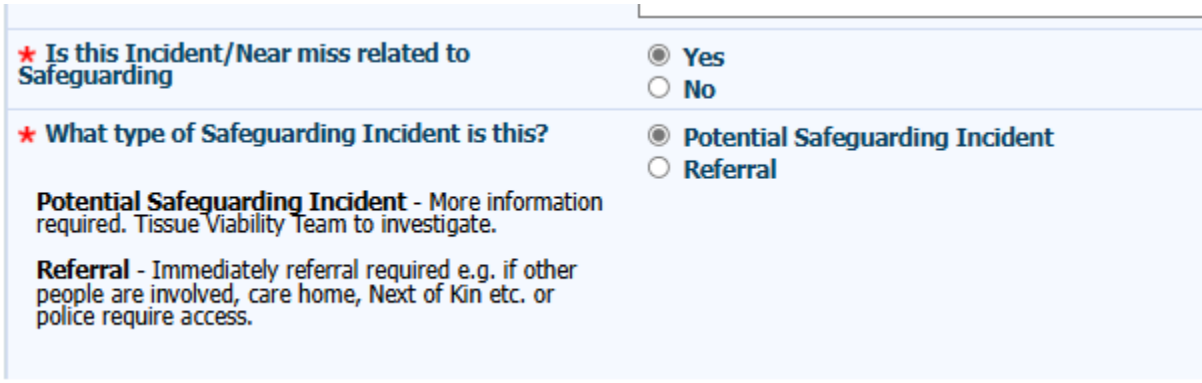
- Where there is evidence of urgent safeguarding concerns the RN/RM will use the Safeguarding flowchart (Appendix A) to decide if a Multi-Agency Safeguarding Hub (MASH) referral is appropriate. If deemed appropriate the MASH referral will be completed, and the Trust's Safeguarding Team and General Practitioner will be informed. A copy of

the MASH referral will be placed in the medical notes Safeguarding section behind the red divider.

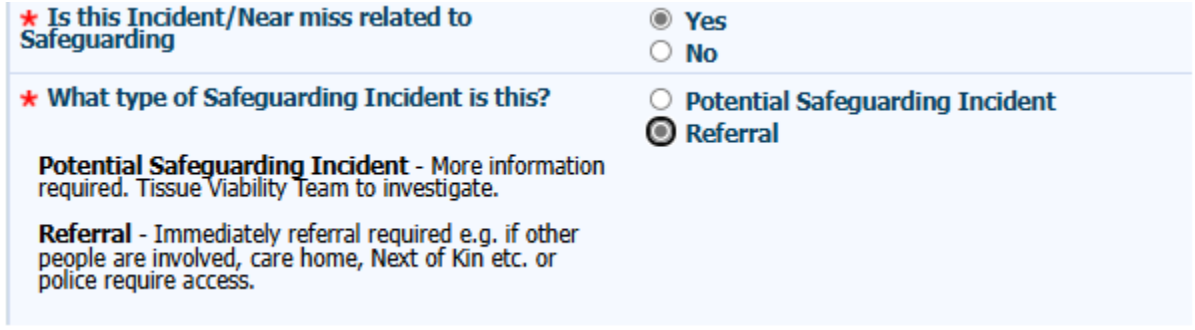
- Complete the PU Datix to record the referral:



- Or is it more appropriate to gain insightful information before making a MASH referral? Complete the Datix to record the 'potential' referral:



- The TVT will make the appropriate enquiries into the patients care, and will use the Safeguarding flowchart (Appendix A) to decide if a Multi-Agency Safeguarding Hub (MASH) referral is appropriate. If deemed appropriate the MASH referral will be completed, and the Trust's Safeguarding Team and General Practitioner will be informed. A copy of the MASH referral will be placed in the medical notes Safeguarding section behind the red divider by the TVT.
- The TVT will complete the Datix



7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit HOW – will this element be monitored (method used)	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc.) and by who)
PU incident rates developed per Division alongside PU threshold levels of Category 2 PU's and zero Category 3 and (with lapses in care)	TVNC/TVLN DDN	COECG Divisional Performance Review meetings and Patient Safety Committee Surgery – Safety and Staffing Meetings	Monthly Monthly	NMAHPC Patient Safety Committee Quality Committee Trust Board
PU Audit (AMaT)	TVNC and TVLN	TVT to complete PU audit – 5 patients quarterly Ward Leaders to complete a minimum of 5 patients monthly	Quarterly-TVN's Monthly-ward staff	COEC and NMAHPC

8.0 TRAINING AND IMPLEMENTATION

All staff working with patients with or at risk of PUs in clinical areas will read and understand the Pressure Ulcer Prevention and Management Policy. Staff that need further education, to escalate to line manager and attend training.

Training by the TVT is available as follows:

- Induction programme for RN, Health Care Support Workers
- Nursing Orientation Pack
- E-Learning for Health modules prior to face-to-face learning
- Tissue Viability training for Preceptorship Nurses and Nursing Associates
- TV Nurse Champion Study Sessions
- Ad hoc Student Nurse teaching
- Tissue viability study days
- On an ad hoc basis during the provision of specialist advice regarding individual patients during the provision of clinical care
- Conference
- Bespoke education can be arranged for and in specific clinical areas
- Tissue Viability intranet site
- Insight days can be arranged with the TVT
- NA on student placement

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix B
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- **Dealey C, Posnett J and Walker A (2012)** Cost of PUs in the United Kingdom Journal of Wound Care Vol 21 No 6, 261-266
- **Department of Health and Social Care (2018)** Safeguarding Adults Protocol: Safeguarding and the interface with a safeguarding enquiry
- **European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance.** Prevention and treatment of pressure ulcers: Clinical Practice Guideline. The International Guideline. https://www.epuap.org/pu-guidelines/.2019.
- **Fletcher, J. (2022)**, National Wound Care Strategy update: Pressure ulcer prevention and the PSIRF exemplar. Vol. 18, 4.

- **Journal of Wound Care (2020)** Device related pressure ulcers SECURE prevention: Consensus Document.

- **National Institute of Clinical Excellence(2014)**. Pressure ulcer prevention and management: Clinical Guideline.CG 179. https://www.nice.org.uk/guidance/cg179/resources/pressure-ulcers-preventionand-management-pdf-35109760631749.
- **National Institute of Clinical Excellence**. Pressure ulcer prevention and management: Clinical Guideline. CG 179. https://www.nice.org.uk/guidance/cg179/resources/pressure-ulcers-preventionand-management-pdf-35109760631749. 2014.
- **National Institute for Health and Care Excellence NICE.** Pressure ulcers: Quality Standard [QS89]. https://www.nice.org.uk/guidance/qs89.2015.
- **National Wound Care Strategy Programme: (2024)** Pressure Ulcer Categorisation Tool
- **National Wound Care Strategy Programme: (2024)** Pressure Ulcer Recommendations and Clinical Pathway. https://future.nhs.uk/gf2.ti/f/1667106/225095141.1/PDF/-/NWCSP%20Pressure%20Ulcer%20Clinical%20Recommendations%20and%20Clinical%20Pathway%2021.05.24.pdf
- **NHS England (2024)** Policy guidance on recording patient safety events and levels of harm.
- **NHS England/ Improvement** (2020) National Pressure Ulcer Prevalence and Quality of Care Audit – Cohorts 1 and 2 National Stop the Pressure Programme: Audit report
- **NHS Improvement (2018)** Pressure ulcers: revised definition and measurement: Summary and recommendations
- **Nixon J, Nelson EA, Rutherford C, et al.** (Pressure UlceR Programme Of reSEarch (PURPOSE): using mixed methods (systematic reviews, prospective cohort, case study, consensus and psychometrics) to identify patient and organisational risk, develop a risk assessment tool and patient reported ..... NIHR Journals Library. 2015.
- **Nursing and Midwifery Council (2018)** The Code –Professional standards of practice and behaviour for nurses, midwives and nursing associates
- **Tissue Viability Society (2012)** Achieving Consensus in Pressure Ulcer Reporting
- **Wounds UK (2014) Best practice statement:** Eliminating PUs

Related SFHFT Documents:

- Wound Care Policy
- Incident Reporting Policy
- Photography and Video Recording Policy
- Policy for Consent to Examination, Treatment and Care
- Policy for Duty of Candour (Being Open)
- Safeguarding Adults Policy

11.0 KEYWORDS

Pressure Ulcer Prevention and Treatment; PUP; damage; care; relieving; relief;

12.0 APPENDICES

Appendix A – Safeguarding Adults with Pressure Ulcers Pathway
Appendix B - Equality Impact Assessment Form

APPENDIX A

Safeguarding Adults with Pressure Ulcers Pathway showcontent.aspx

APPENDIX B
Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Stephanie Anstess		**Date of EIA completion: 30.10.25**
Department: Tissue Viability		**Division: Surgery**
Name of service/policy/procedure being reviewed or created: Pressure Ulcer Prevention and Management Policy		
Name of person responsible for service/policy/procedure: Stephanie Anstess		
Brief summary of policy, procedure or service being assessed: Policy for clinical staff to reduce pressure ulcer harms and to manage existing PU's		
Please state who this policy will affect: Patients, Carers or families, Commissioned Services,		
Protected Characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening. Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.**
Race and Ethnicity	Patients with dark skin tones must be assessed differently as dark skin tone doesn't blanch.	Training is included for staff on the assessment required for dark skin which includes looking at the colour, temperature, localised pain and texture.
Sex	None	
Age	None	
Religion and Belief	None	
Disability	None	
Sexuality	None	

Pregnancy and Maternity	None	
Gender Reassignment	None	

Marriage and Civil Partnership	None	
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	

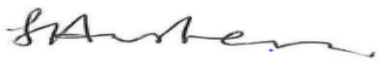
If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

What consultation with protected characteristic groups including patient groups have you carried out? **Race and Ethnicity**
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? **No**

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)						
Positive			**Negative**			
High	**Medium**	**Low**	**Nil**	**Low**	**Medium**	**High**
If you identified positive impact, please outline the details here:						

Protected Characteristic	**Please explain, using examples of evidence and data, what the impact of the Policy, Procedure or Service/Clinical Guideline will be on the protected characteristic group.**	**Please outline any further actions to be taken to address and mitigate or remove any in barriers that have been identified.**
Race and Ethnicity	The policy which is based on the National Wound care Strategy Pressure Ulcer Guidelines advises patients with dark skin tone (DST) to be assessed differently from patients with light skin tones(LST), as DST does not react to pressure i.e. it does not go red and does not blanch when applying pressure with a finger.	The RN has to choose the right skin assessment template for the patient. I.e. DST or LST. If the patient has dark skin tones the RN has to check the skin over pressure areas by checking for darker skin discolouration which is a sign of pressure damage. Also checking skin temperature changes, texture: induration and softness, and localised pain.
Gender		
Age		
Religion		
Disability		
Sexuality		
Pregnancy and Maternity		
Gender Reassignment		

Marriage and Civil Partnership		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)		

Signature:    *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*
Date: 30/10/25