safeguarding adults at risk
a cumbria partnership

Guidance Paper 5
Pressure Ulcers

December 2015

Cumbria Safeguarding Adults Board

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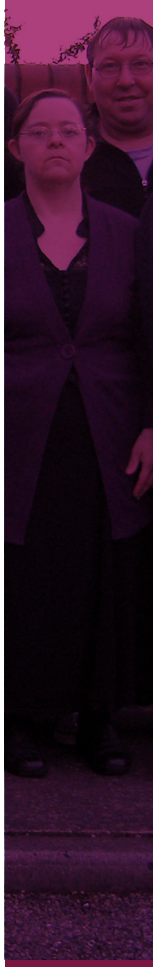
1. Introduction



This is a county wide protocol which provides guidance for staff in all health and social care sectors in Cumbria who are concerned that a pressure ulcer (or other forms of skin damage) may have arisen as a result of poor practice or neglect, and therefore have to decide whether to make a Safeguarding Adults referral alert.

Pressure ulcers illustrate well the challenge of finding out whether an issue is caused by poor care or avoidable neglect, or whether it is the unavoidable result of a person's current condition. While pressure ulcers are always a risk for people who are frail and are not able to move about easily, with good management and care they can usually be avoided.

The simple fact that an adult at risk has a pressure ulcer – even a serious one – is not in itself a reason to suspect abuse or neglect. There are a number of factors to help you decide whether it potentially indicates neglect, or whether it indicates a need for care providers to improve their practice.

These factors include:

- The person's physical health and existing medical conditions
- Any skin conditions the person may have
- Any other signs of neglect, such as poor personal hygiene
- The appropriateness of their care plan and whether it has been properly carried out
- The person's own views, and the views of their family and friends, on their treatment and care

These factors should be looked at by a clinician asked by the relevant NHS Trust or the CCG to establish whether the person's pressure ulcers are the result of poor practice that can be improved, or whether intentional or avoidable neglect is taking place. If the issue is neglect, a decision will need to be made as to whether there is a risk to other adults receiving services from the same provider.

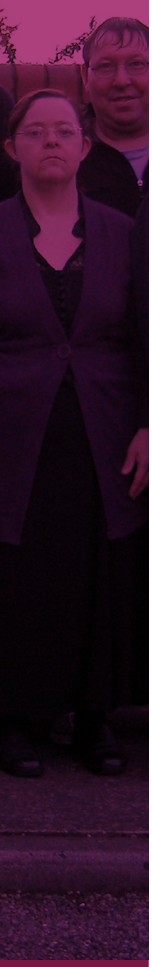
The nature and timing of this, and who leads it, will depend on the circumstances of the individual case. The conclusion may be that the problem can be resolved by the service provider.

Where it appears that the pressure ulcers are the result of abuse or neglect the concern should be reported to the local authority under s42 of the Care Act 2014:

It may be apparent that external clinical intervention or regulatory enforcement action is required
If the pressure ulcers amount to the wilful neglect of people who lack mental capacity, a crime under s44 of the Mental Capacity Act 2005 may have occurred and the police should be informed

Staff should refer to the latest version of:

- Cumbria Safeguarding Adults Policy and Procedures
- Your own organisation's policies and procedures on pressure ulcers
- Other relevant local and national guidelines, protocols and policies



2. Definition

- A pressure ulcer is a localised injury to the skin and/or underlying tissue over a bony prominence , as a result of pressure, or pressure in combination with shear.
- Pressure ulcers can develop very quickly. Without appropriate intervention they can become very
- serious. Any pressure ulcer can be painful and cause patient suffering but severe pressure ulcers can destroy the muscle or bone and in extreme cases they can cause infection and become life threatening.

3. Risk Factors

Anyone can get a pressure ulcer but some people are more at risk than others. Identifying those at higher risk will help identify appropriate prevention measures. The factors that make people most at risk are listed below:

- Pressure – the weight of the body pressing down on the skin
- Shearing - the tearing and stretching of the skin caused by a patient sliding down or being dragged up the bed, combined with the patient's weight
- Reduced mobility or immobility
- Lack of feeling/sensation in the skin
- Severe/chronic or terminal illness
    - Acute illness e.g. chest infection
- Levels of consciousness
- Extremes of age (over 65, under 5)
- Extremes of weight
- Previous history of pressure damage
- Poor nutritional input (malnutrition and/or dehydration)
- Medication e.g. night sedation or strong pain killers, steroids, vasoconstrictors
- Moisture (incontinence, leaking wounds, perspiration)
- Vascular disease
- Inappropriate treatment decisions, including timeliness
    - Undergoing surgery
    - Critical care
    - Non-concordance
    - End of life

4. Skin Inspection

Skin inspection provides essential information for pressure ulcer prevention. Regular inspection of vulnerable parts of the body will enable early detection of tissue damage. Frequency should be based on the vulnerability and condition of the patient. Skin should be inspected for any redness or change of colour.

If it is not possible to see redness on the skin of people with darkly pigmented skin, then it should be assessed for the following signs:

- Darkening of the skin
- Localised heat
- Localised swelling
- Localised hardening of the skin
- Blistering or a break in the skin.

Any skin changes noted should be documented immediately and discussed with the patient and the multidisciplinary team. Body maps should be used to record these.

The areas of the body that are most vulnerable are typically:

- Heels
- Sacrum/base of the spine
- Buttocks
- Hips
- Elbows
- Back or side of head
- Ears
- Shoulders
- Toes
- Parts of the body that are affected by the wearing of anti-embolic stockings
- Parts of the body where pressure, friction or shear is exerted in the course of their daily activities e.g. on the hands of wheel chair users
- Parts of the body where there are external forces exerted by equipment and clothing e.g. catheters, intravenous lines, shoes.

5. Prevention and intervention

It is better to take care that an issue/problem does not happen than to have to solve the problem/issue afterwards. It is easier to stop something bad from happening in the first place than to fix the damage after it has happened. Timeliness of intervention is a key component of prevention.

Preventative measures should be tailored to the individual's needs. The following preventative interventions should be considered for all people identified at risk to prevent significant pressure ulcers from occurring and thus reducing the harm to individuals.

a. Assessment

The initial assessment must consider six key questions:

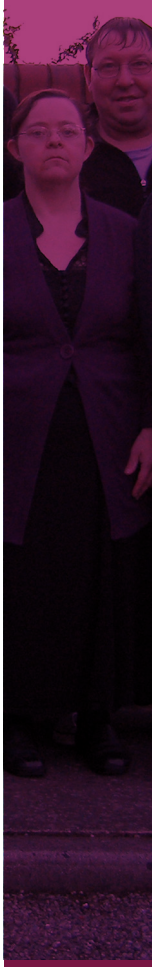
1. Has there been a rapid onset and /or deterioration of skin integrity?
2. Has there been a recent change in medical condition that could have contributed to a sudden deterioration of skin condition?

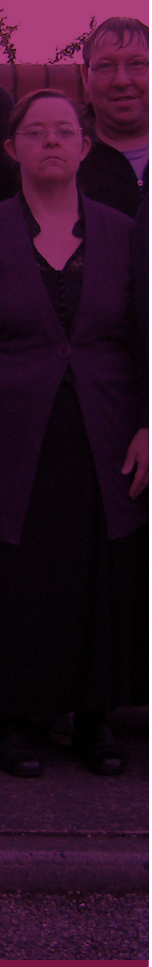
- skin or wound infection
- other infection
- pyrexia
- anaemia
- end of life care

3. Have reasonable steps been taken to prevent skin damage?
4. Is the level of damage to the skin disproportionate to the person's risk status for skin damage?
5. Is there evidence of poor practice or neglect?
6. Is the person an adult at risk, as defined by the Cumbria Safeguarding Adults Procedures?

Photographic evidence to support any report should be provided wherever possible.
Consent must be sought for taking photographs. Any photographs must record the size of the wound as well as date/time taken.

Early identification of people at high risk of pressure ulcers will ensure preventative measures can be implemented quickly. The use of a formal risk assessment tool, such as the Waterlow Risk Assessment Tool, will ensure all risk factors are assessed in a consistent way.





Paper based risk assessments should not be completed in isolation but in conjunction with a thorough skin inspection of the most at risk areas (as listed above).

Risk assessments must be completed:

- On all people requiring care
- At regular intervals
- If an individual's care needs change

Visual skin assessments must be carried out each time personal care is given.

b. Mobility

One of the best ways of preventing pressure ulcers is to reduce or relieve pressure on the areas of skin that are vulnerable. This can be done by encouraging or assisting the patient to move or change position as often as needed to prevent persistent redness of the skin. If a patient already has a pressure ulcer, lying or sitting on this area should be avoided as much as possible. The following is recommended:

- At risk people should have an individual care plan, identifying a repositioning regime.
- Individuals should be given advice about how to change their position in bed/chair and how often they should do this to prevent pressure ulcers developing.
- People that need support to move or transfer should be assisted in a way that reduces the risk of friction or shearing.
- If a patient's skin condition is deteriorating despite a regular and frequent turning regime then a specialist mattress and/or cushion should be used.

c. Aids and Equipment

There are many different types of mattresses and cushions that can help to reduce the pressure on bony parts of the body and help prevent pressure ulcers.

All Health and Social care providers must ensure that people using their services are provided with equipment and aids that meet their needs and promote their comfort, safety and dignity.

The selection of equipment should be based on:

- Risk assessment
- Pressure ulcer assessment if present
- Location and cause of the pressure ulcer if present
- Skin assessment
- General health
- Lifestyle and abilities
- Critical care needs
- Acceptability and comfort
- Availability of carer/healthcare professional to reposition patient
- Patient weight
- Cost considerations

Consideration should be given to all surfaces used by the patient. It is best practice for patients to have 24 hour access to pressure relieving devices and/or strategies. Such devices should be changed in response to individual need, condition and level of risk. It is recommended that all vulnerable patients, including those with a grade 1-2 pressure ulcer, should receive, as a minimum provision, a high specification foam mattress.

It is important to note that specialized equipment will not eliminate the need for regular turning or changing positions.

d. Nutrition

Eating well and drinking enough fluids is very important to help reduce people's risk of developing pressure ulcers. It is particularly important for those with a pressure ulcer as their wound can fail to heal without a good diet.

At risk patients should have a nutritional assessment carried out and/or referral to dietician services for dietary advice.

Full records of what high risk individuals eat and drink in a day will help to identify if someone is eating and drinking sufficiently.

e. Continence Management

If skin is exposed to moisture for long periods of time it can become macerated, resulting in a loss of integrity and tissue damage in the form of moisture lesions.

Moisture lesions:

- Superficial lesions or spots comprising partial-thickness skin loss with diffuse or irregular edges
- Lesions may extend either side of the anal area and present as a kissing or copy lesion
- There will be moisture present and the skin will appear shiny or wet
- The surrounding skin often has blanchable or non-blanchable erythema, as well as pink or white macerated tissue
- There is generally no necrosis present with these lesions although if they get infected they will enlarge and deepen.

The most common causes of moisture are:

- Urinary and/or faecal incontinence
- Perspiration
- Wound leakage

The following is recommended:

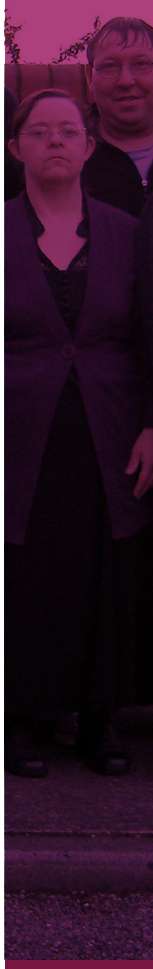
- Use of foam cleansers or wash creams instead of soap and water
- Barrier products may be required but should be used sparingly.
- Use of incontinence pads should be chosen depending on the individuals needs and fitted correctly.
- Urinary catheterisation should be viewed as a last resort.

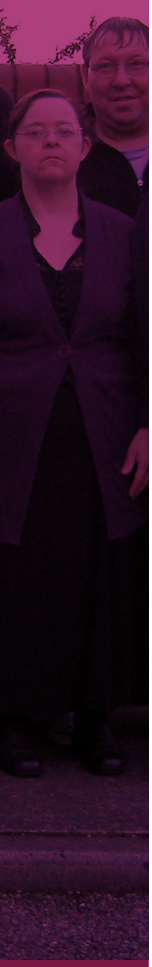
f. Skin Care

Skin that is dry or sensitive will be more susceptible to becoming damaged by friction and shearing.

Things to consider:

- The use of emollients to keep skin in good condition
- Do not rub skin but pat it dry
- If the patient insists on using talcum powder, they should be advised to use it sparingly.
- Keep beds and chairs free from crumbs and wrinkles
- Check clothing and footwear for prominent seams or zips that may cause skin damage.





g. Record Keeping and Information Sharing

Good record keeping is essential to demonstrate full assessments have been completed and to identify the care or treatment required.

The following records must be kept in relation to pressure ulcers:

- Assessments (including risk and skin assessments)
- Individual care plan
- Consent to treatment
- Daily records of care given
- Completed body maps, dated and signed

h. Training and Education

All staff involved with the health and care of adult or adults at risk must have access to training, information and guidance on Pressure Ulcers. Such training, information and guidance must be appropriate to their role and responsibilities. The requirements of Regulators must be met.

As a minimum all staff must have access to this guidance.

References

www.epuap.org

www.nice.org.uk/CG029

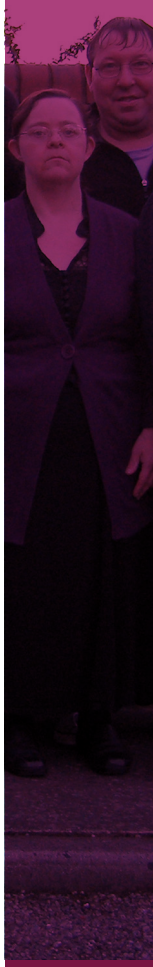
Solihull Metropolitan Borough Council (2011) Practice Guidance No. 4 Pressure Ulcers Safeguarding Adults (Section 16)

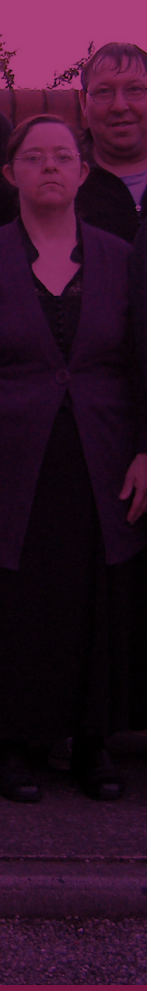
No Pressure Ulcers

Nutrition
Observation

Preventions is better than cure
Risk is predictable
Equipment, aid and adaptations
Some are more vulnerable to pressure ulcers
Skin care
Understand individual's roles and responsibilities
Review – individual's care, capacity, practice and systems
Education and training

Up and walking, turning, evaluation
Lift don't drag
Continence
Everybody's business
Record keeping
Safeguarding





Pressure Ulcers – Safeguarding Triggers

To determine if the identification of a pressure ulcer on an individual with care and support needs should be reported as a adult safeguarding alert the following triggers should be considered:

THIS GUIDE IS FOR STAFF BUT DOESN'T REPLACE CLINICAL JUDGEMENT.
IF IN DOUBT, SEEK ADVICE FROM YOUR SAFEGUARDING LEAD *or* REPORT AS A SAFEGUARDING ALERT.

1. What is the severity (Grade) of the pressure ulcer?	**Grade 2 or below.** **Not serious incident reportable.** **Monitoring only.**	**Several Grade 2** **Grade 3 and 4 and one or more of the factors below.** **Serious incident reportable**	**Grade 3 or 4 and one or more of the factors below.** **Serious incident reportable.**
2. Has the individual been compliant with treatment?	Has refused treatment.	Has refused treatment or treatment not provided.	Has refused treatment or treatment not provided.
3. Full assessment completed and care plan developed in a timely manner and care plan implemented?	Documentation and equipment available to demonstrate full assessment completed. Care plan developed and implemented. Support sought from GP, DN or SW.	Documentation and equipment not fully available to demonstrate full assessment completed or care plan developed and implemented. (Fact finding) BUT, general care regime not of concern….ie nutrition/hydration. Or evidence not clear.	Little or no evidence of documentation, assessment, care planning AND general care regime is of concern…ie nutrition/hydration.
4. This incident is part of a trend or pattern. There have been similar incidents with this individual or others.	Evidence suggests that this is an isolated incident for this individual.	There have been other similar incidents for this individual.	Evidence indicates that this is part of a pattern or trend for this individual.
5. Carer raised concerns and sought support at an appropriate time	Evidence indicates that concerns raised and support sought from GP, DN, SW.	Evidence not clear that concerns were raised and support sought in a timely manner.	No support sought.
Conclusion	**No safeguarding alert at this stage.** **Hospital setting: Clinician led, continue to monitor.** **Community setting: Clinician led, continue to monitor**	**Possible safeguarding alert.** **Clinician led enquiry to determine what action needs to be taken** **Abuse or neglect identified, report to Local Authority**	**Report as a Safeguarding alert immediately.** **Clinician led enquiry to determine what action needs to be taken as a result of Safeguarding Strategy**

Capacity	**Grade Guide**
• Has capacity been considered? • If treatment is refused, capacity to be recorded.	Grade 1 & 2 – superficial damage Grade 3 & 4 – deep damage suspected.