NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

The management of Pressure Ulcers under Safeguarding across the Borough of Sefton

Community and Mental Health Services

This guidance has been produced by a partnership of agencies working with adults in Sefton.

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In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

Version Number	Type of Change	Date	Description of change

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Introduction

Pressure ulceration is often preventable and the overarching guidance for pressure ulcer prevention and management is provided within National Institute for Clinical Excellence (NICE 2014) Clinical Guideline and Quality Standard 89 (2015).

This guidance has been produced to support practitioners across Sefton working with adults with care and support needs that may present with skin damage. It is based on the Department Of Health and Social Care guidance 'Safeguarding Adults Protocol: pressure ulcers and the interface with a safeguarding enquiry (2018)'.

Where pressure ulcers do occur, this guidance offers a clear process for the management of removal and reduction of harm to the individual, whilst considering whether an adult safeguarding response under s42 of Care Act 2014 is necessary.

Scope

This document is intended for broad circulation supporting health and social care professionals, providers and across communities.

Overview

This guidance contains a critical document devised by the Department of Health and Social Care (2018) 'Adult Safeguarding Decision Guide' (Appendix 3) which will guide activities once the need for assessment of pressure ulcers is identified.

This document also contains three separate flowcharts providing guidance on the prompt management of pressure ulcers:

- Flowchart 1 – NHS Provider Acquired Pressure Ulcer (Appendix 1A)
- Flowchart 2 – Nursing Home Acquired Pressure Ulcer (Appendix 1B)
- Flowchart 3 – Residential / Domiciliary Care/ Community Acquired Pressure Ulcer (Appendix 1C)

This guidance contains information about how to classify pressure ulcers (Appendix 2).

Key Questions:

Does the individual have carers whether paid or unpaid?

- Pressure ulcers may occur as a result of neglect and acts of omission by a third party.

Is there evidence of neglect and acts of omission?

- If **ALL** care needs have not been met **OR** the individual has been denied / had delayed access to health, social care and education services **OR** the individual has been denied / had delayed access to medication, adequate nutrition and heating **THEN** there is a strong possibility that the pressure damage may have been avoidable.

Have the individual's needs or clinical presentation changed?

- Re-assessment of skin integrity and risk factors should be completed every time there is a change for the individual no matter how small.

What is pressure damage?

- Sustained pressure – prolonged contact between skin (particularly over a bony prominence) and a supporting surface.
- External shear force – i.e. when an individual slides down the bed (often seen on the sacrum and heels).

Could the pressure damage be prevented?

- Not all pressure damage is preventable.
- All individuals should be considered on an individual basis considering the risks (both internal and external).
- Care plans should be in place, reviewed and updates regularly and whenever there is a change for the individual.

Is the damage as a result of moisture?

- If the patient is incontinent or moisture is present this is **NOT** a pressure ulcer and shouldn't be recorded as such.
- Consideration should still be given to how the skin damage occurred and whether or not it was as a result of neglect or acts of omission.

Has the individual recently moved / had surgery or an intervention?

- Everyone who has had surgery or moved from one care environment to another should have their risk of developing a pressure ulcer re-assessed (NICE 2015).

Have you checked the feet?

- Having little fat on them and coming into pressure contact with most surfaces feet are at high risk of pressure damage.
- Heels are the second most common area of pressure ulceration (Morton 2012).

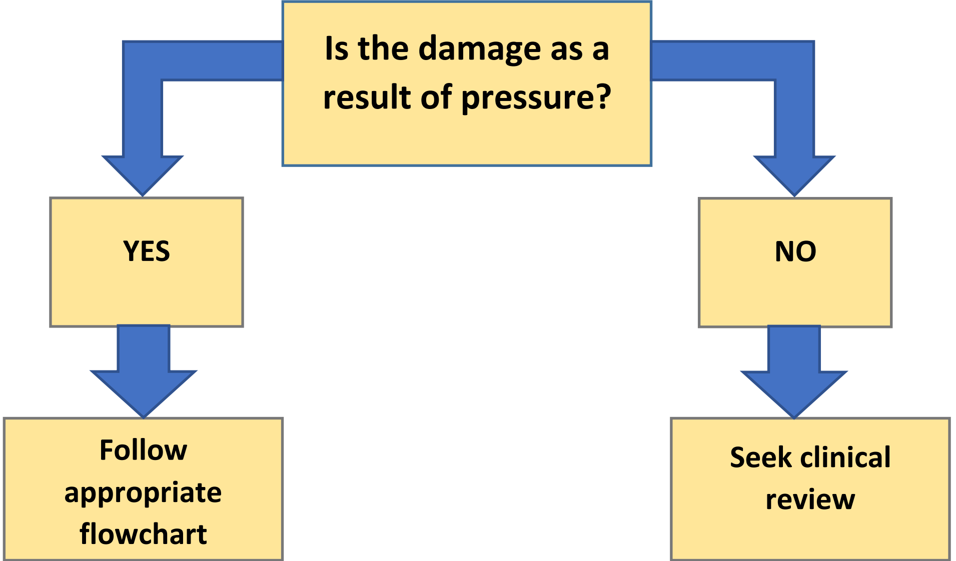
HAVE YOU CONSIDERED RISK FACTORS AND ACTED APPROPRIATELY AND QUICKLY?

REFER TO YOUR OWN AGENCY POLICY ON PRESSURE ULCER MANAGEMENT AND PREVENTION

RISK FACTORS TO CONSIDER

SKIN INTEGRITY ISSUES	RISK ISSUES
Current or previous pressure ulcers	Ongoing use of medical devices
Low body fat	Significantly limited mobility
Low muscle bulk	Wheelchair uses

WHAT TO DO WHEN YOU DISCOVER SKIN DAMAGE



- On identifying skin damage as a result of pressure, the Adult Safeguarding Decision Guide (Appendix 3) should be completed by a qualified member of staff who is a practising Registered Nurse (RN) with experience in wound management and not directly involved in the provision of care to the service user.

- The decision guide **MUST** be completed within **48 hours** of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for the extension **MUST** be documented on the Decision Guide **and** in the individual's care notes.

- If further advice/support is needed to make the decision whether to raise a concern with Local Authority, consult your Adult Safeguarding Lead or the most senior manager within your organisation. The final decision to embark on a section 42 will remain with the Local Authority, informed by a clinical view.

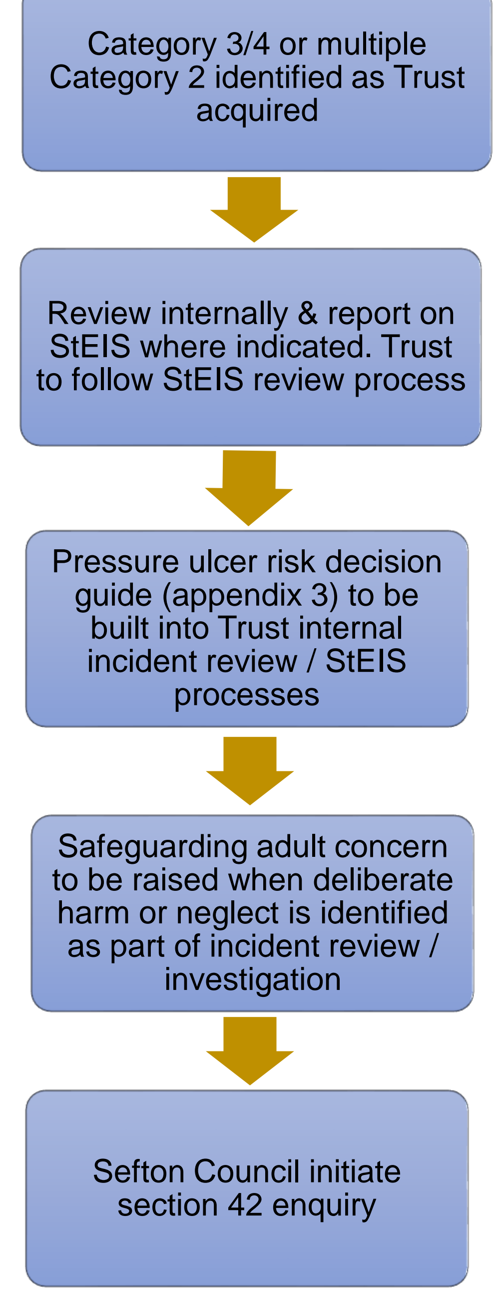
- The completed Decision Guide considers 6 key questions to determine if a concern needs to be raised with the Local Authority.

- It is **CRITICAL** that the concern is raised immediately where:

    1. There are concerns that the pressure ulcer developed as a result of carer **wilfully ignoring or preventing** access to care or services.
    2. There are any concerns regarding **abuse or neglect** of the person receiving care.

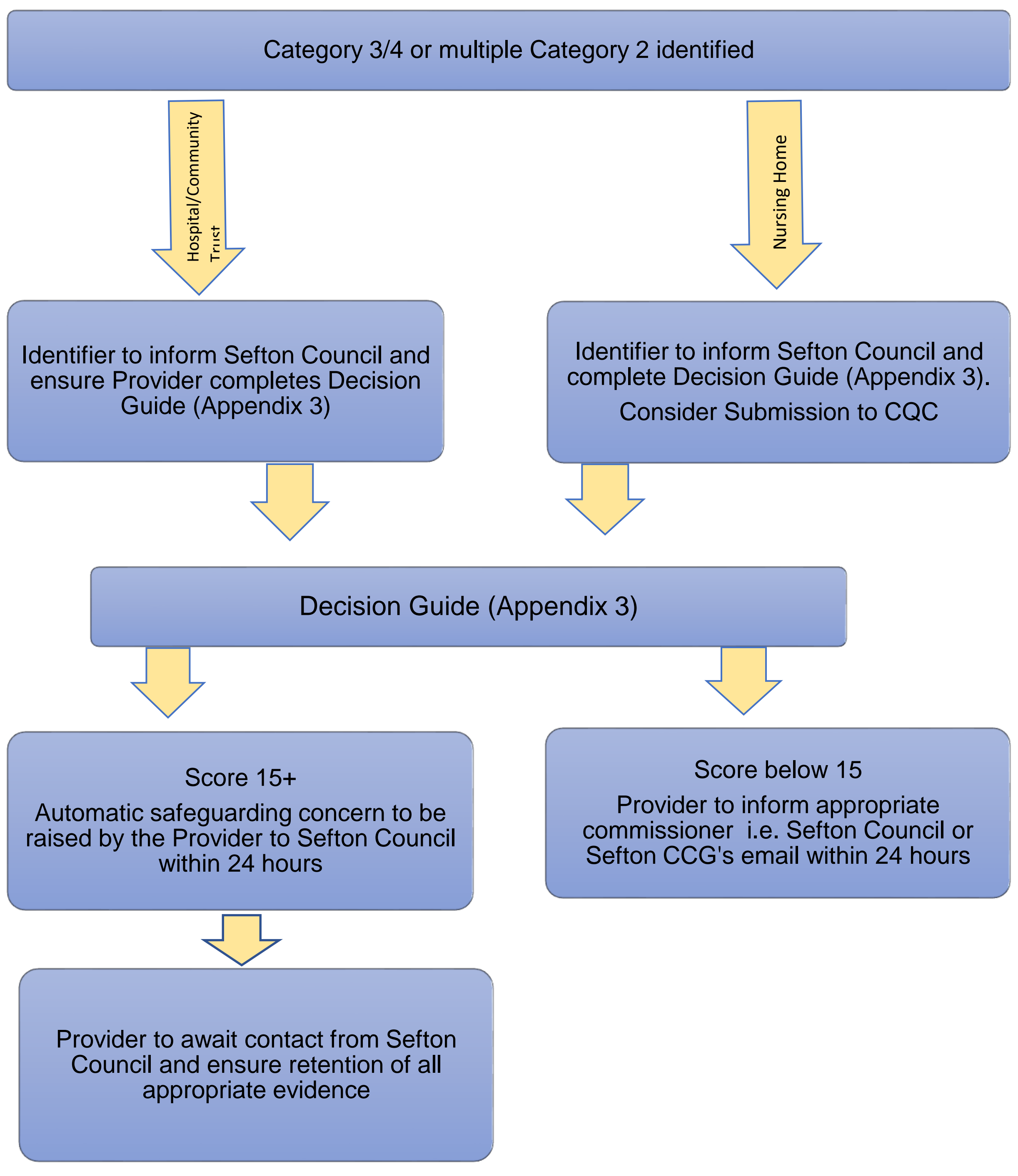
Appendix 1A

Flowchart 1 – NHS Provider Acquired Pressure Ulcer



Appendix 1B

Flowchart 2 – Nursing Home Acquired Pressure Ulcer



Appendix 1C

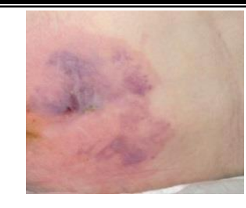
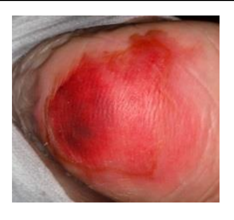
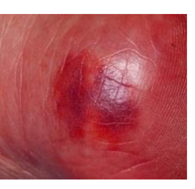
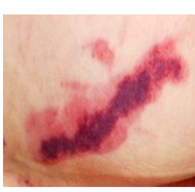
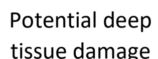
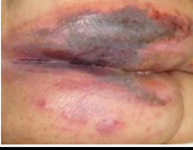
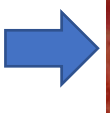
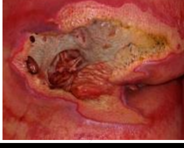
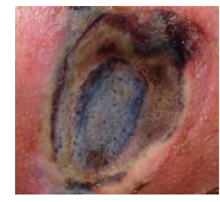
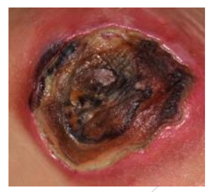
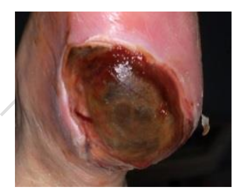
Flowchart 3 – Residential/ Domiciliary Care/ Community / Own Home Acquired Pressure Ulcer

Appendix 2

NORTH WEST TISSUE VIABILITY NURSES –

CLASSIFICATION OF PRESSURE ULCERS

Category	Examples
CATEGORY (GRADE) 1 Intact skin. Non blanching redness. Usually occurs over bony prominence. Individuals with dark skin, observe for additional signs e.g. warmth, oedema, pain, hardness.	Blanching redness Non blanching redness
CATEGORY (GRADE) 2 Superficial skin loss. Pink/Red wound bed. May be very minimal slough with healthy tissue clearly evident. May present as a clear filled blister with no discoloration underneath.	superficial skin loss with minimal slough Clear blister Superficial skin loss Partially deroofed blister
CATEGORY (GRADE) 3 Full thickness tissue loss., Subcutaneous fat may be visible but bone/tendon/muscle are not exposed. Depth may vary depending on anatomical location.	
CATEGORY (GRADE) 4 Full thickness loss. Can extend to expose bone/tendon or muscle or they may be directly palpable. Depth can vary by anatomical location.	

POTENTIAL DEEP TISSUE DAMAGE **A localised area of purple discoloration over intact skin, or blood blister, due to damage of underlying soft tissue. It may be painful, firm, mushy, boggy, warmer or cooler compared to the adjacent skin. May develop into a category 3 or 4 but cannot be confirmed until extent of damage is evident. Damage may be recoverable with effective 'off-loading' of affected area.**	        Grade 4 pressure ulcer
UNSTAGEABLE **GRADE TO BE DETERMINED AT A LATER DATE** **Minimal category 3 but potential 4. The wound bed is not visible due to presence of slough or necrotic tissue. Classification may not be possible until the ulcer is debrided.**	  

Moisture Associated Skin Damage -Pressure Ulcer or Moisture Associated Skin Damage?

	Pressure Ulcer		Moisture Associated Skin Damage	
Causes		Pressure / shear	Moisture eg. Shining / wet	
Location		Bony prominence	Skin fold, anal cleft (sharp edge), perianal area	
Shape		Takes the form of the causative pressure	Diffuse superficial spots, "kissing lesions"	
Depth		Superficial or deep	Superficial wounds	
Necrosis		Black necrotic scab	No necrosis	
Edges		Distinct Edges	Diffuse edges and irregular lesions	
Colour		Non Blanchable erythema	Red but not uniformly distributed, pink or white surrounding skin	

Appendix 3

Department of Health and Social Care (2018) Adult Safeguarding Decision Guide

	Patient Name: Patient DOB:	NHS#:	Patient Address:	
Q	**Risk Category**	**Level of Concern**	**Score**	**Evidence**
1	Has the patient's skin deteriorated to either cat 3/4/ unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/ visit	Yes e.g. record of blanching / non-blanching erythema /cat 2 progressing to multiple cat 2 or cat 3 or cat 4	5	E.g. evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
		No e.g. no previous skin integrity issues or no previous contact health or social care services	0	
2	Has there been a recent change? i.e. within days or hours, in their / clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anaemia, end of life care, critical illness	Change in condition contributing to skin damage	0	
		No change in condition that could contribute to skin damage	5	

	Patient Name: Patient DOB:	NHS#:	Patient Address:	
3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	0	State date of assessment Risk tool used Score / Risk level
		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	What elements of care plan are in place
		No or incomplete risk assessment and/or care plan carried out	15	What elements would have been expected to be in place but were not
4	Is there a concern that the Pressure Ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services	No / Not applicable	0	
		Yes	15	
5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk–Category 3 or 4 pressure ulcer	Skin damage less severe than patient's risk assessment suggests is proportional	0	

	Patient Name: Patient DOB:	NHS#:	Patient Address:	
		Skin damage more severe than patient's 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 of the care plan or some capacity to consent to some but not the entire care plan.			
a	Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Patient has not followed care plan and local non concordance policies have been followed.	0	
		Patient followed some aspects of care plan but not all	3	
		Patient followed care plan or not given information to enable them to make an informed choice.	5	
b	Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice? (supported by documentation, e.g. capacity and best interest statements and record of care delivered)	Documentation of care being undertaken in patient's best interests	0	

	Patient Name: Patient DOB:	NHS#:	Patient Address:	
		No documentation of care being undertaken in patient's best interests	10	
	Total Score			

If the score is 15 or over, discuss with Sefton Council reflecting the urgency of the situation. When the decision guide has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the patient's notes.

Note: Where there is <u>***suspected abuse or neglect***</u> the health care practitioner MUST immediately submit a safeguarding concern, irrespective of Category of Pressure Damage .