Cambridgeshire and Peterborough Safeguarding Adults Boards

Practice Guidance on Pressure Ulcers

1. What is the purpose of this guidance

This guidance is intended to inform staff who are concerned that a pressure ulcer (or other forms of skin damage) may have arisen as a result of poor practice, neglect, acts of omission or deliberate harm, and therefore have to decide whether to raise a safeguarding alert in line with the local multi agency Safeguarding policy and procedures.

The guidance outlines basic information about the prevention and development of pressure ulcers and when these should be considered as a safeguarding concern. This does not replace individual organisations' pressure ulcer guidance but provides advice on when pressure ulcers should be referred under the adult safeguarding procedures.

It provides guidance to staff in the Cambridgeshire and Peterborough Safeguarding Adults Boards locality:

- Adult Social Care Staff
- Domiciliary Care Staff in relation to referring a pressure ulcer under adult safeguarding procedures and the management of pressure ulcers.
- Staff working in residential and nursing homes
- NHS providers including, community nursing and hospital staff

The guidance could also be of interest to those who want to learn more about pressure ulcers.

2. What is a pressure ulcer and how is it caused?

A pressure ulcer is a localised injury to the skin and / or underlying tissue usually over a bony prominence. This can be the result of

Pressure
Body weight and some equipment (e.g. catheter) can press on the skin, other tissues and bone. This reduces the blood supply to the area and can lead to skin damage.

Shearing
Sliding or slumping down a bed/chair can cause damage by stretching and tearing the skin and deeper tissue layers.

Friction
Poor moving and handling methods can remove the top layers of skin. Repeated rubbing can increase the risk.

Pressure ulcers can develop very quickly and without appropriate intervention can become very serious. Any pressure ulcer can be painful and cause suffering but severe pressure ulcers can expose bone, and in extreme cases they can cause infection and become life threatening.

Typically they occur in a person confined to bed or a chair by an illness and as a result they are sometimes referred to as 'bedsores', or 'pressure sores'.

Pressure ulcers are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Pressure ulcers can occur in people of all ages.

3. What do pressure ulcers look like?

Please refer to images on the chart on the next page, p.3.

Superficial – Grade 1

Skin appears discoloured and is red in white people, and purple or blue in people with darker colored skin.
Skin does not turn white when pressure is placed on it
Skin remains intact but it may hurt or itch. Skin may also feel either warm, cold spongy, or hard.

Grade 2

Some of the outer surface of the skin (the epidermis) or the deeper layer of skin (the dermis) is damaged, leading to skin loss.
Skin looks like an open wound or a blister

Deep – Grade 3

Skin loss occurs throughout the entire thickness of the skin.
The underlying tissue is also damaged. The underlying muscle and bone are not damaged.
The ulcer appears as a deep, cavity-like wound, (image 1), (image 2), or (image 3)
bruising deep tissue injury with top of skin intact or (image 4) Black hard necrosis (dead) tissue.

Grade 4

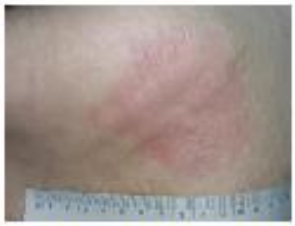
The skin is severely damaged and the surrounding tissue begins to die (tissue necrosis). The underlying muscles or bone may also be damaged. People with grade four pressure ulcers have a high risk of developing a life-threatening infection.

Pressure ulcer grading chart

NHS
Midlands and East

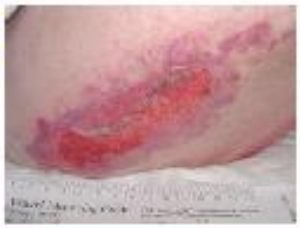
Adapted from EPUAP/NPUAP 2009

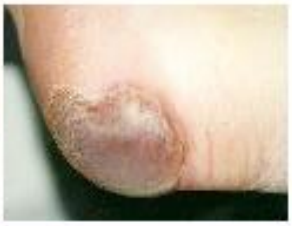
Superficial



EPUAP - Category/Grade I

- Non-blanchable erythema of intact skin: persistent redness in lightly pigmented skin.
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple.
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).



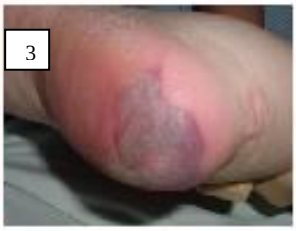


EPUAP System- Category/Grade 2

- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising*
- Check for moisture lesion.

*Bruising appearance and blood filled blister would indicate deep tissue injury.

Deep

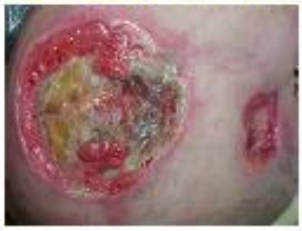


EPUAP - Category/Grade 3

- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep grade 3 pressure ulcers.
- Bone/tendon is not visible or directly palpable.

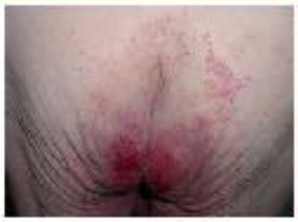
Plus: Unclassified PU - now Grade 3

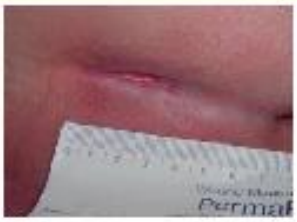
- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either grade 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as 'the body natural (biological) cover' and should not be removed.
- Should be documented as grade 3 until proven otherwise.



EPUAP - Category/Grade 4

- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow.
- Grade 4 ulcers can extend into the muscle and/or supporting structures (eg fascia, tendon or joint capsule).





Moisture Lesions

- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.

4. **Does the grade of a pressure ulcer reflect how serious it is and whether a safeguarding referral should be considered?**

It has been recognised that it is unhelpful to rely solely on pressure ulcer grading in deciding the seriousness of the cause, or consequences to the patient[1]. The grading of a pressure ulcer alone is also an unreliable indicator of whether or not there are possible related safeguarding concerns.

Staff should ensure they follow their own organisation's incident reporting policy and procedures around Pressure Ulcers.

Care providers are required to notify the Care Quality Commission about a person who develops a grade 3 or 4 pressure ulcer after admission to that service/ care home/hospital
http://www.cqc.org.uk/content/regulation-18-notification-other-incidents#full-regulation

5. **Is it inevitable that pressure ulcers will develop?**

No. Pressure ulcers are mostly preventable or avoidable, providing the person has received appropriate care and treatment. However, for some they may still develop pressure ulcers despite them receiving appropriate care and treatment.

Root causes;

- Pressure
- Shearing (the tearing and stretching of the skin caused by a person sliding down or being dragged up the bed, combined with the individual's weight) associated with:
- Friction (the rubbing of the skin causing superficial abrasions)

There are risk factors which make people more likely to be susceptible to developing a pressure ulcer. These include

- Reduced mobility or immobility
- Lack of feeling/sensation in the skin
- Long term chronic 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
- Medication e.g. night sedation or strong pain killers, steroids
- Moisture (incontinence, leaking wounds, perspiration)

5.1 Avoidable Pressure Ulcer:

'Avoidable' means that the person receiving care developed a pressure ulcer and the provider of care did NOT do one of the following:

- evaluate the person's clinical condition and pressure ulcer risk factors
- plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice;

- monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

5.2 Unavoidable Pressure Ulcer:

'Unavoidable' means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence.

Circumstances could include:

- Where the person condition means that they cannot be repositioned frequently such as those with a spinal injury.
- When those receiving care as part of an end-of-life pathway may not be able to tolerate repositioning as frequently as their skin may require. Skin is an organ and can fail and breakdown into a pressure ulcer at the end of life.
- Where a person has not previously been seen by a healthcare professional
- When a person is known to a healthcare professional but an acute/critical event occurs which affects mobility or the ability to reposition; for example the patient being undiscovered for a period following a fall or loss of consciousness
- When a person declines advice and care

6. How can pressure ulcers be prevented?

If you think a person is at risk of developing a pressure ulcer, you should undertake the following actions or refer to a district nurse.

6.1 Assessments

Early identification of people at high risk of pressure ulcers will ensure preventative measures can be implemented quickly. Any risk assessments should not be completed in isolation and clinical judgement is important.

The Waterlow Risk Assessment Tool is a nationally recognised tool for identifying those who are at risk of developing a pressure ulcer (See example, Form A). Visual skin assessments must be carried out each time personal care is given, the findings must be documented and the care plan updated depending on the findings.

Nutrition and hydration are important factors and these should be assessed using a tool such as the Malnutrition Universal Screening Tool (MUST), which is the most commonly used screening tool in the UK to assess malnutrition. Resources and information can be found at:
http://www.bapen.org.uk/screening-for-malnutrition/must/introducing-must

Once all of the risk assessments have been completed, then a plan of care to prevent the development of pressure ulcers can be developed and appropriate measure put in place. This needs to be documented and reviewed so that all staff are aware of what care is required.

6.2 Skin care and Inspection

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

Things to consider:

- Do not rub or massage the skin but pat it dry
- If the individual 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
- The use of ring cushions is not recommended

Skin inspection provides essential information for pressure ulcer prevention. Frequency of inspection will be dependent on a person's condition and is likely to be at least daily. The following are early signs of a pressure ulcer developing mostly on a bone:

- Change in skin colour, redder (and remains red when pressure is applied) or darker than normal. In darker skin, it might appear grey or purple
- Patches of hot or cold skin
- Discomfort, pain, itching
- Blistering, swelling or broken skin

Without appropriate intervention the damage may worsen, developing into hard black tissue or an open wound. Reddening of the skin that disappears shortly after pressure is removed is normal and not a pressure ulcer

Any skin changes noted should be documented immediately and discussed with the individual and the multidisciplinary team. See forms B & C as examples of documentation used to record skin inspections and areas of concern.

6.3 Mobility and repositioning

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 person to move or change position as often as needed to prevent persistent redness of the skin. If an individual 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. A chart may be needed to document this.
- People 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 person's skin condition is deteriorating despite a regular and frequent turning regime then specialist pressure relieving equipment should be used such as a mattress and/or cushion

6.4 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. It is important to document what is being used and that it has been checked to ensure it is being used correctly and not broken.

All Health and Social care providers must ensure that if equipment has been given to a person to use that they are actually using it and that it is in working order.

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

6.5 Nutrition

Eating well and drinking enough fluids is very important to help reduce people's risk of developing pressure ulcers and effective wound healing.
If there are concerns regarding whether a service user has sufficient nutrition and fluid intake, a food and fluid intake chart should be implemented.

6.6 Moisture Control

If skin is exposed to moisture for long periods of time it can cause skin damage: moisture lesions, excoriation, or dermatitis. The most common causes of moisture are:

- Urinary and/or faecal incontinence
- Sweating
- Wound fluid

Moisture lesions must not be confused with pressure ulcers. These are usually on soft tissues (e.g. buttocks) and may look like a "nappy rash" but can be associated with pressure ulcers.

Ensure that skin is clean and dry; consider assessment for continence aids and a possible referral to a GP or the continence adviser if required.

7. How can you know if a Pressure Ulcer *was* avoidable, or not?

The only way to assess if a persons pressure ulcer could have been avoided is to undertake a review of their care to identify whether all the required assessments and preventative actions were in place in a timely way. This may be done by registered nursing staff or by referral to the district nurse. This will include;

- Significant health history – physical and mental
- Consideration of whether or not there has there been rapid onset of a deterioration in health
- The person's compliance, capacity and behaviour with advice and care
- Were their needs assessed? Was the assessment complete and accurate – was the assessment robust?
- Was a care plan developed to meet the needs identified in the risk assessment?
- Was there evidence that the care plan was implemented and reviewed?
- Was pressure relieving equipment provided in a timely way and appropriate to care needs?
- Was there referral to specialist help such as a tissue viability nurse?
- Have staff had appropriate training in the prevention of pressure ulcers?
- Was care documented and relevant charts completed?

8. If you assess that a pressure ulcer was avoidable, what next?

If, following the review it is felt that the pressure ulcer was avoidable because the service and support they were receiving had **NOT** taken all appropriate measures available to them in a timely manner then a safeguarding referral should be made to the Local Authority Safeguarding Adults team. A decision will then be made about what action to take and whether there have been any criminal actions which would need to be referred to the Police. See Appendix A for a summary

The care plan for the person should be reviewed to ensure that all measures are in place to prevent further deterioration and more pressure ulcers developing.

Consideration also needs to be given as to whether the pressure ulcer needs to be reported as a Serious incident if the care was NHS funded.

The person or family should be informed under the Duty of Candour requirements **(**CQC regulation 20)

9. Training & Education

All staff involved with the health and care of people must have access to training, information and guidance on the prevention of pressure ulcers and skin damage. Such training, information and guidance must be appropriate to their role and responsibilities.

All staff must be up to date with their training and learning in line with their organisational policy and organisations must have a system to record details of training and training requirements for each member of staff

10. Quality Monitoring

The following will ensure quality monitoring is successful:

- All staff receive support and clinical supervision in the form of a discussion with a peer or manager / professional on a regular basis regarding complex cases or scenarios which the member of staff would like to review.
- Organisations and agencies have systems in place for checking that prevention of pressure ulcer practices are in place, assessments are being undertaken and care plans implemented and that staff are attending training
- Organisations and agencies should check trends and patterns of pressure ulcers including grades of pressure ulcers, equipment used and any contributing factors so improvements can be identified and implemented.
- Compliance with performance indicators should be included in contracts with care homes and care providers and compliance should be monitored.

11. Concerns Which Require Escalation

Refer to the Peterborough Safeguarding Adults and Cambridgeshire Safeguarding Adults Multi-Agency policies and procedures available on the on the links below.

Peterborough; http://www.peterboroughlscb.org.uk/adults-board/information-for-adults/ Report a Concern
Cambridgeshire:
http://www.cambridgeshire.gov.uk/info/20166/working_together/582/adult_safeguarding_policy_and_procedures Worried about an adult or older person

12. Further Reference Materials

The “stop the pressure” website contains further useful information:
http://www.stopthepressure.com/path/

http://www.england.nhs.uk/wp-content/uploads/2015/03/serious-incident-framwrk-15-16-faqs-fin.pdf p.7
https://www.nice.org.uk/guidance/cg179
https://www.nice.org.uk/guidance/cg179/resources/cg179-pressure-ulcers-algorithm-for-risk-assessment-prevention-and-management-in-adults-
https://www.nice.org.uk/guidance/cg179/resources/cg179-pressure-ulcers-algorithm-for-risk-assessment-prevention-and-management-in-adults-2

http://nhs.stopthepressure.co.uk/Path/docs/Definition%20unavoidable%20PU.pdf
http://www.cqc.org.uk/content/regulation-20-duty-candour
https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf
http://ageuk.org.uk/Documents/EN-GB/Factsheets/FS62_Deprivation_of_Liberty_Safeguards_fcs.pdf?dtrk=true
http://www.scie.org.uk/publications/ataglance/ataglance43.asp
http://www.cqc.org.uk/content/regulation-18-notification-other-incidents#full-regulation

13. Contributors to this review

This guidance was initially developed in 2012 updated in November 2015, and ratified in May 2016. Contributors included:

- Cambridgeshire and Peterborough Clinical Commissioning Group Safeguarding Team
- Safeguarding teams from Cambridgeshire and Peterborough NHS Foundation Trust and Addenbrookes Hospital
- Tissue Viability Nurses from Cambridgeshire and Peterborough NHS Foundation Trust and Addenbrookes Hospital

Appendix A

Pressure Ulcers –Safeguarding Triggers for an individual with a pressure ulcer in any setting.

This table can be used to help determine if the identification of a pressure ulcer on an individual should result in a safeguarding referral. It can also be used by Adult Social Care staff to help with their decision making as to whether there is a need to investigate under the safeguarding adult procedures.

	Possibly not safeguarding at this stage	**Possibly Safeguarding**	**Safeguarding referral**
1. What is the severity of the pressure ulcer? (Grade)	Grade 1 or 2 pressure ulcer – care plan required.	Several Grade 2 pressure ulcers or Grade 3 or 4 pressure ulcers - consider question 2 below about mental capacity.	Grade 4 and other issues of significant concern Any pressure Grade 2,3,4 pressure ulcer assessed as avoidable
2. Does the individual have mental capacity and have they been compliant with treatment? Has a capacity assessment been completed?	Has capacity and has refused / declined treatment. Capacity assessment is recorded.	Does not have capacity or capacity has not been assessed -continue to question 3 below.	Assessed as NOT having capacity and treatment NOT provided.
3. Provider has completed pressure care assessment and care plan developed in a timely manner and care plan implemented? **OR** Concerns raised by unpaid carers	Documentation and equipment available to demonstrate full assessment completed, care plan developed and implemented. **OR** Evidence available to show concerns raised and support or advice sought – e.g. from GP, DN, SW	Documentation and equipment NOT fully available to demonstrate full assessment completed, care plan developed or implemented BUT general care regime (e.g. nutrition, hydration) not of concern - continue to question 4 below **OR** Evidence NOT CLEAR that concerns were raised or support or advice sought in a timely manner.	Little or no documentation available to demonstrate a full assessment has been completed, or care plan developed or implemented AND general care regime (e.g. nutrition, hydration) is of concern. **OR** No support or advice sought
4. This incident is part of a trend or pattern - there have been other similar incidents with this individual or others.	Evidence suggests this is an isolated incident. Continue observing individual but no further action required at this stage	There have been other similar incidents.	Evidence demonstrates this is part of a pattern or trend.
	NOT SAFEGUARDING	**DISCUSS WITH MANAGER AND DOCUMENT DECISION AND ACTIONS**	**SAFEGUARDING REFERRAL AND DOCUMENT DECISIONS AND ACTIONS**

IF IN DOUBT

- **Discuss with senior manger**
- **Initiate Safeguarding Adults Procedures**
- **Record decisions and reasons**

FORM A. Example Skin Inspection Form

NAME:														
Date & Time														
Head														
Left Ear														
Right Ear														
Left Elbow														
Right Elbow														
Sacrum														
Left Buttock														
Right Buttock														
Left Hip														
Right Hip														
Left Knee														
Right Knee														
Left Heel														
Right Heel														
Left Ankle														
Right Ankle														
Other Please state														
Sign/initial														

Normal Appearance 0
Change in Appearance 1

If 1 is written there must be an entry in the care records stating what the change is, the intervention required and when the intervention has been completed.

FORM B. Example Body Map Guidance

A Body Map should be used to document and illustrate visible signs of harm and physical injuries.

Clearly mark on the body map:

- Pressure ulcers
- Red areas
- Bruises
- Cuts, lacerations and wounds
- Scalds and burns
- Swellings.
- Insect Bites
- Existing scars, birth marks etc.

Provide details such as:

- Size, measure if possible or compare to a common object e.g. size of a 10p coin.
- Colour
- Grade of pressure ulcer – if known.

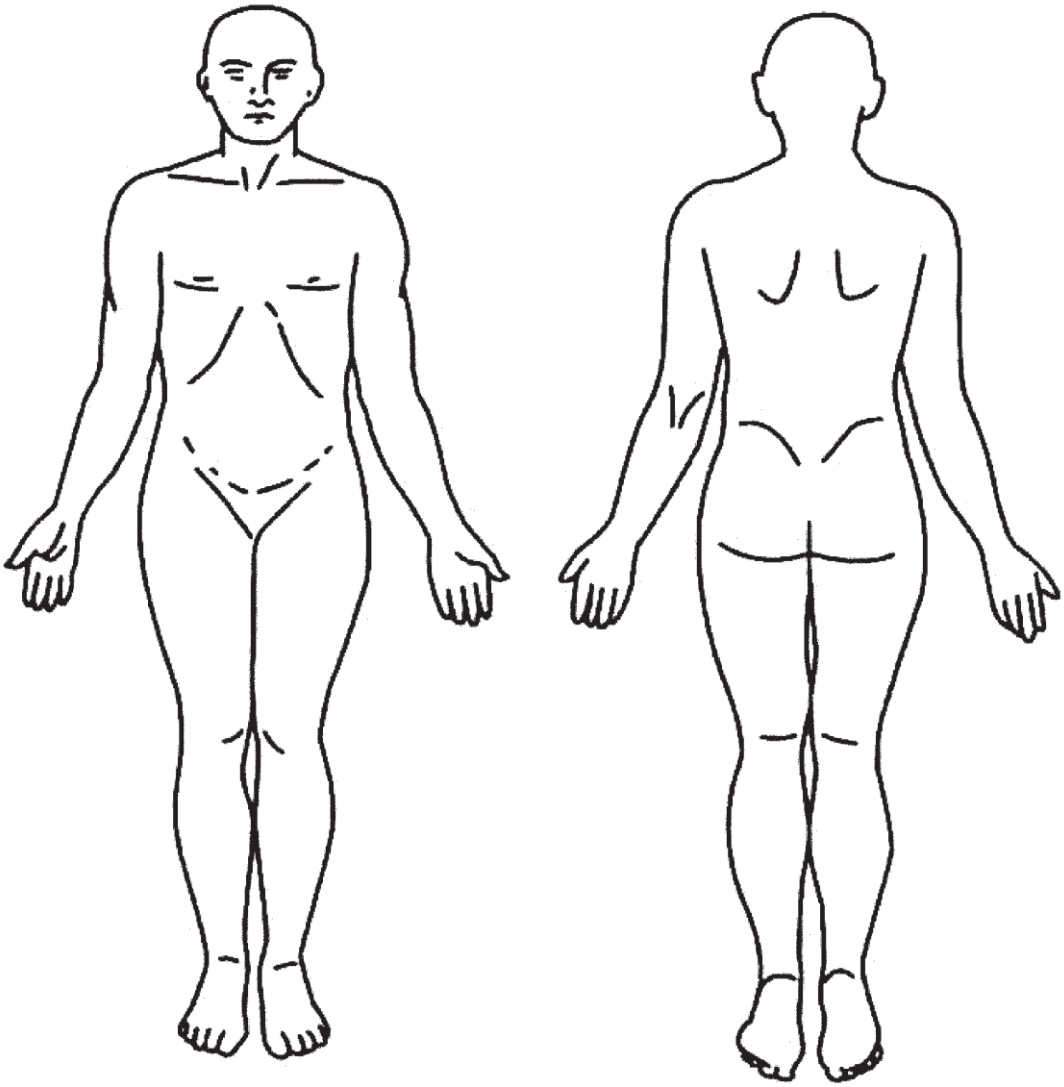
Always record:

- The date of the record
- The time the record was made and
- The name and designation of the person making the record.

Use the notes section to add any further comments.
As the wound or mark changes a new record should be made.
A copy of all body charts must be kept in the individuals records.
Always use a black pen

BODY MAP

Name:
Date:



Notes:

FORM C. Example Skin Assessment Tool - (Waterlow)

Undertake and document risk assessment within 6 hours of admission or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol.

More than one score/category can be used:
10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk'

Sex									
Male	1								
Female	2								
Age									
14 – 49	1								
50 – 64	2								
65 – 74	3								
75 – 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m^2)									
Average – BMI 20-24.9	0								
Above average – BMI 25-29.9	1								
Obese – BMI > 30	2								
Below average – BMI < 20	3								
Continence									
Complete/catheterised	0								
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type – Visual Risks Area									
Healthy	0								
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0								
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by severe pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4								
Chair bound (unable to leave chair without assistance)	5								
Nutritional Element									
Unplanned weight loss in past 3-6 months									
< 5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2								
BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient/ client acutely ill or no nutritional intake > 5 days	2								

Special Risks – Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8								
Single organ failure e.g. cardiac, renal, respiratory	5								
Peripheral vascular disease	5								
Anaemia = Hb < 8	2								
Smoking	1								
Special Risks – Neurological Deficit									
Diabetes/ MS/ CVA/ motor/ sensory/ paraplegia *Max 6*	4-6								
Special Risks – Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/ below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5								
Special Risks – Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4								
Total Score									
Date									
Initials									
Time									

Ensure plan of care is implemented / reviewed for all identified areas of concern.

(Adapted form from Scotland NHS Quality Improvement Waterlow Pressure Area Risk Assessment Chart)