



Pressure Ulcer Guidance

Approved :

Review and Version Control:

Version	Date	Author/Reviewer	Comments

These guidelines were developed by a Task and Finish group, working on behalf of the Cambridgeshire and Peterborough Safeguarding Adults Board, and were adopted by the SAB in July 2019.

Membership of the group included:

- CPFT (TVN, Neighbourhood Team Nurses, Safe Guarding Lead, MDT Co Coordinator)
- Social Care: Cambs County Council, Cambs MASH
- Papworth (TVN)
- CCG (Lead Nurse for Care Homes, Safe Guarding)
- SAB
- NWAFT (TVN)
- Care Homes

The following guidelines were written to support the Pressure Ulcer Protocol Published by Department of Health & Social Care in January 2018, and aim to assist practitioners understand the interface between the protocol and a safeguarding enquiry.

What is a pressure ulcer?

A pressure ulcer is an area of damage to the skin and underlying tissue. They are sometimes known as pressure sores or bed sores.

What causes a pressure ulcer?

Pressure ulcers are caused by poor circulation to tissues due to a combination of the following factors:

- **Pressure**
Body weight and some equipment (e.g. anti-thrombosis stockings) can squash the skin and other tissues where parts are under pressure. This reduces the blood supply to the area and can lead to tissue damage.
- **Shearing**
Sliding or slumping down the bed/chair can damage the skin and deeper layers of tissue.
- **Friction**
Poor moving and handling methods can remove the top layers of skin. Repeated friction can increase your risk.

Who is most at risk of developing pressure ulcer?

You may be at risk of developing pressure ulcers for a number of reasons including the following:

- **Problems with movement**
If your ability to move is limited and you are unable to change position regularly or are in a wheel chair.
- **Poor circulation**
Vascular disease or smoking reduces your circulation.
- **Moist skin**
You may be at increased risk if your skin is too damp.
- **Lack of sensitivity to pain or discomfort**

Conditions such as diabetes, stroke, nerve/muscle disorders reduce the normal sensations that usually prompt you, or enable you to move. Some treatments (e.g. epidural pain relief, medication, operations) reduce your sensitivity to pain or discomfort so that you are not aware of the need to move.

- **Previous tissue damage**

Scar tissue will have lost some of its previous strength and is more prone to breakdown.

- **Inadequate diet or fluid intake**

Lack of fluid may dehydrate your tissues. Weight gain or loss can affect the pressure distribution over bony points and healing.

- **People having problems with memory**

and understanding who may not be able to follow advice and guidance.

Risk Assessment

To assess your risk of developing pressure ulcers, a member of your health care team will examine/asses you and ask you some questions. This will help to identify if you require any specialised equipment or other forms of care, and will assist in providing for your individual needs.

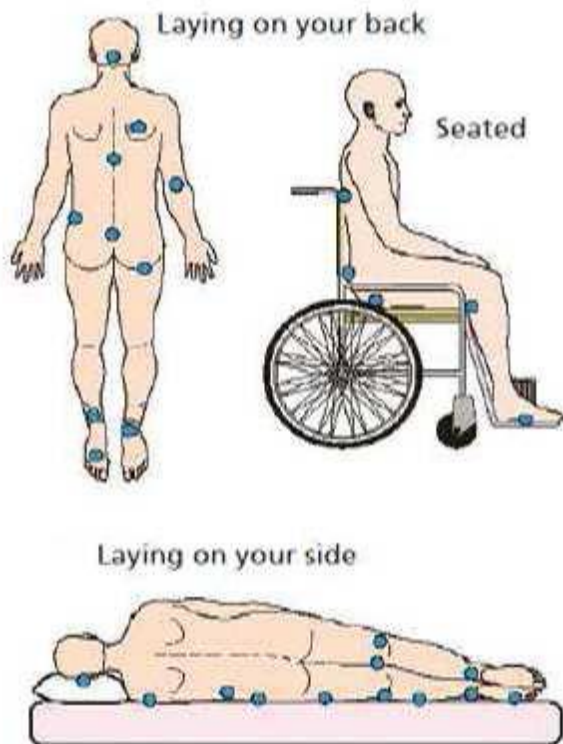
What are the early signs of a pressure ulcer?

You will notice the following signs:

- Change in skin colour, redder or darker
- Heat or cold
- Discomfort or pain
- Blistering, swelling
- Skin damage

Without appropriate intervention the damage may worsen, developing into hard black tissue or an open wound.

Common locations of pressure ulcers



Reference: Whiting NL (2009) Skin assessment of patients at risk of pressure ulcers. Nursing Standard vol 24 no. 10 pages 40 – 44

What can I do to avoid pressure ulcers?

There are several ways you can reduce the risk of pressure ulcers.

- **Keep moving**
Changing your position regularly helps keep blood flowing. If you have reduced movement the health care team looking after you will assist you with regular turns in addition to providing specialist mattresses, cushions and other equipment.
- **Look for signs of damage**
Check your skin for pressure damage at least once a day. Look for skin that doesn't go back to its normal colour after you have taken your weight off it. Do not continue to lie on skin that is redder or darker than usual. Also watch out for blisters, dry patches or breaks in the skin.
- **Protect your skin**
Wash your skin using warm water and non-perfumed soap. If you suffer from incontinence please inform your health care team as they can assess the best way to deal with your problems. Rubbing/massaging using a ring cushion is not recommended.
- **Eat a well-balanced diet**
Make sure you eat a healthy balanced diet and drink plenty of fluids. Extra protein may help.

What should I do if I suspect a pressure ulcer?

Tell your doctor or nurse as soon as possible and follow the advice they give you.

Pressure Ulcers can be a safeguarding concern. This is more likely where the ulcer is avoidable and serious in its impact. They are frequently associated with other safeguarding concerns, such as neglect and self-neglect. These can include poor diet, inadequate care and inappropriate physical handling. Pressure Ulcers can be the result of appropriate equipment not being accepted or used, which could be Domestic Abuse.

It is vital that any consideration of Pressure Ulcers being linked to safeguarding includes a wider consideration of whether other concerns over abuse and/or neglect are present for the Adult at Risk.

Professional and medical information on the identification, assessment and treatment of Pressure Ulcers can be found at:

- [NHS Guidance](#)
- [NICE Guidance](#)
- [Prevention and Treatment of Pressure Ulcers: Quick Reference Guide](#)

Information for the wider public is available at

<https://www.nice.org.uk/guidance/cg179/ifp/chapter/What-is-a-pressure-ulcer>

Local resources

CPFT provide District Nursing Services for Cambridgeshire and Peterborough. For smaller providers without Tissue Viability Nurses then advice should be sought from the GP or, if they have one, the adult's District Nurse. Resources and guidance is available on CPFT's website at

<https://www.cpft.nhs.uk/search-results.htm?sitekit=true&task=search&indexname=Site&blah=&search=PRESSUE+ULCERS>

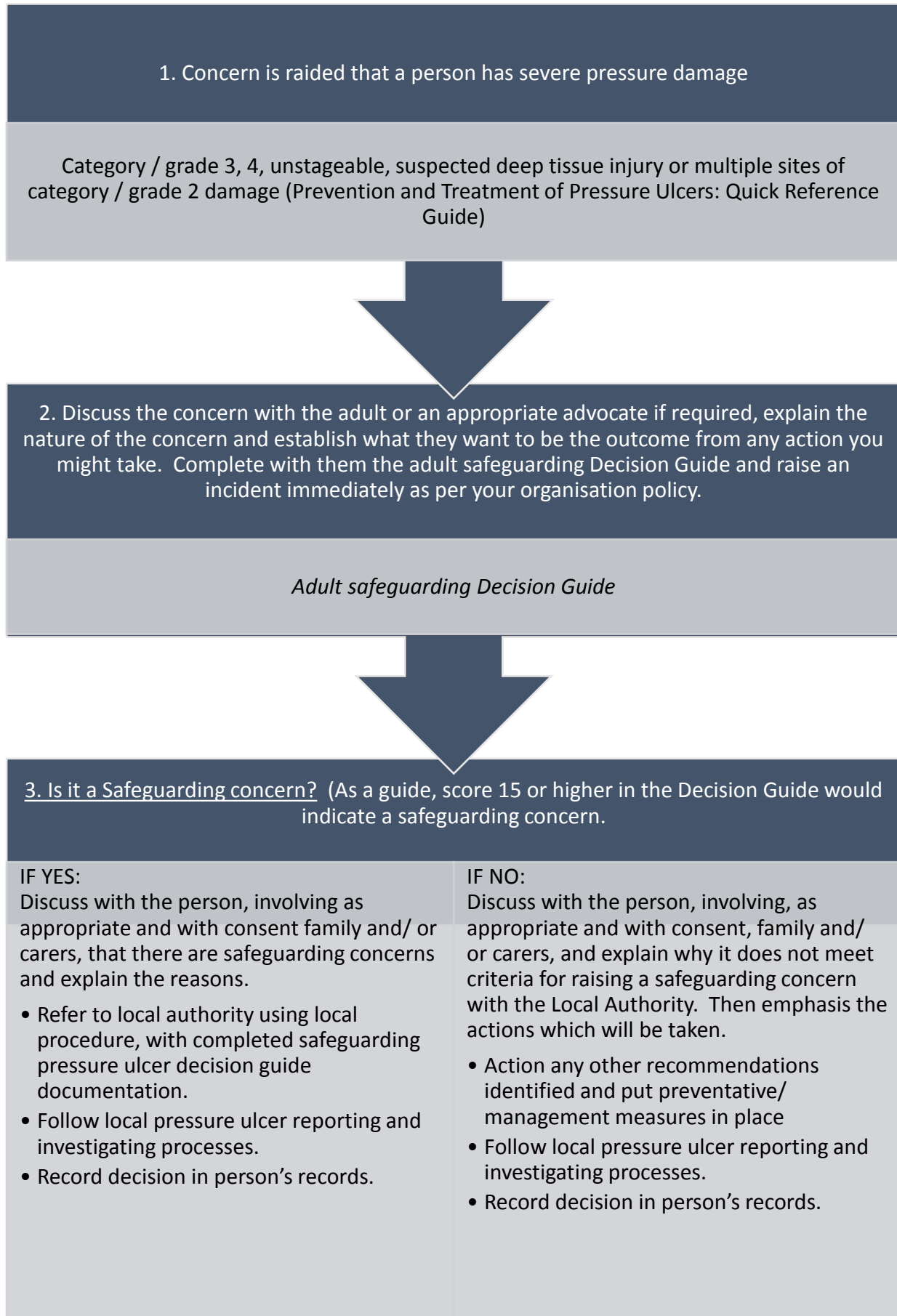
<https://improvement.nhs.uk/resources/Using-SSKIN-to-manage-and-prevent-pressure-damage/>

Safeguarding

To assist in deciding whether an ulcer should be considered a safeguarding concern, there is a national Safeguarding Protocol that can be found at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675192/CSW_ulcer_protocol_guidance.pdf

FLOW CHART



Adult Safeguarding Decision Guide for individuals with severe pressure ulcers

Qtn.	Risk Category	Level of Concern	Score	Evidence
1	Has the patient's skin deteriorated to either grade 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 /grade 2 progressing to grade 2 or more	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	
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	No / Not applicable	0	
		Yes	15	

	ignoring or preventing access to care or services			
5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk–Category/ grade 3 or 4 pressure ulcer	Skin damage less severe than patient's risk assessment suggests is proportional	0	
		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	
		No documentation of care being undertaken in patient's best interests	10	
TOTAL SCORE				

If the score is 15 or over, discuss with the local authority (safeguarding) as determined by local procedures and 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.

Adults Name:

Adults Patient No:

Name of assessing nurse (PRINT)			
Job Title			
Name of second assessor (PRINT)		Signature	
Job Title		Signature	