Barking and Dagenham

Pressure Ulcer Protocol

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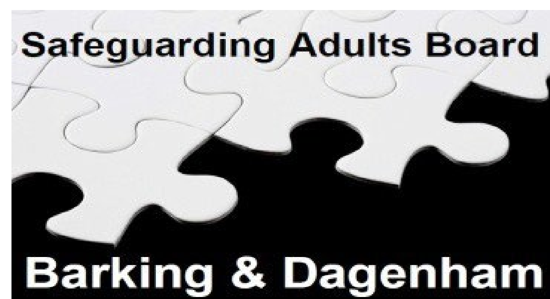

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The Pressure Ulcer Protocol 1

1.1 About this Pressure Ulcer Protocol

This local protocol was developed with local partners and professionals, to support practice to the National Guidance. This protocol supports practitioners to understand the interface between pressures ulcers and safeguarding enquiries.

Everyone who provides care to an adult is required to report pressure ulcers under the duty of care. All professionals are reminded of the Duty of Candour and to report serious incidents and safeguarding concerns in line with their local policies and procedures.

These guidelines were developed by a multi-agency group, working on behalf of the Barking and Dagenham Safeguarding Adults Board, and adopted in February 2022.

The Pressure Ulcer Protocol, Published by Department of Health & Social Care in January 2018, is paramount, and it is essential that everyone reads and follows this guidance in full. This can be found here:

https://www.gov.uk/government/publications/pressure-ulcers-safeguarding-adults-protocol

1.1 Membership of the working group

Membership of the working group included:

- Adult Social Care and the Commissioning Team, London Borough Barking and Dagenham
- North East London Foundation Trust (NELFT)
- Barking Havering Redbridge University Trust (BHRUT)
- Clinical Commissioning Group (CCG)
- Consultation has also taken place with commissioned services, care homes, home care providers and personal assistants in the development of this protocol.

Pressure Ulcers 2

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

2.1 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.

2.2 What could increase the risk of developing pressure ulcers?

There are a number of things that could increase a persons' chances of developing pressure ulcers.

- **Inadequate diet or fluid intake**
  Lack of fluid can dehydrate your skin and tissue. Weight gain or loss can affect the pressure distribution over bony points and healing.

- **Problems with movement**
  If your ability to move is limited and you are unable to change position regularly or are in a wheelchair.

- **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**
  If someone cannot feel pain they may not realise a pressure ulcer is developing.

- **Conditions such as diabetes, stroke, nerve and muscle disorders**
  These reduce the normal sensations that usually prompt you or enable you to move.

- **Prognosis**
  If there a diagnosis or prognosis that outlines how the person's skin integrity may be affected, especially if there has been recent change in their clinical condition that could have contributed to skin damage. E.g. infection, pyrexia, anaemia, end of life care (skin changes at life end) or critical illness.

- **Treatments such as epidural pain relief, medication and operations**
  These can reduce your sensitivity to pain or discomfort so that you are not aware of the need to move.

- **Tissue damage or scar tissue**
  If you have experienced previous tissue damage or have scar tissue the skin may have lost some of its previous strength and is therefore more prone to breakdown.

- **Lack of memory and understanding**
  People who may not be able to follow advice and guidance could be at higher risk. It is advised that a risk assessment is undertaken to assess the risk of developing pressure ulcers. This will help to identify the person's individual needs and whether they require any specialised equipment or other forms of care.

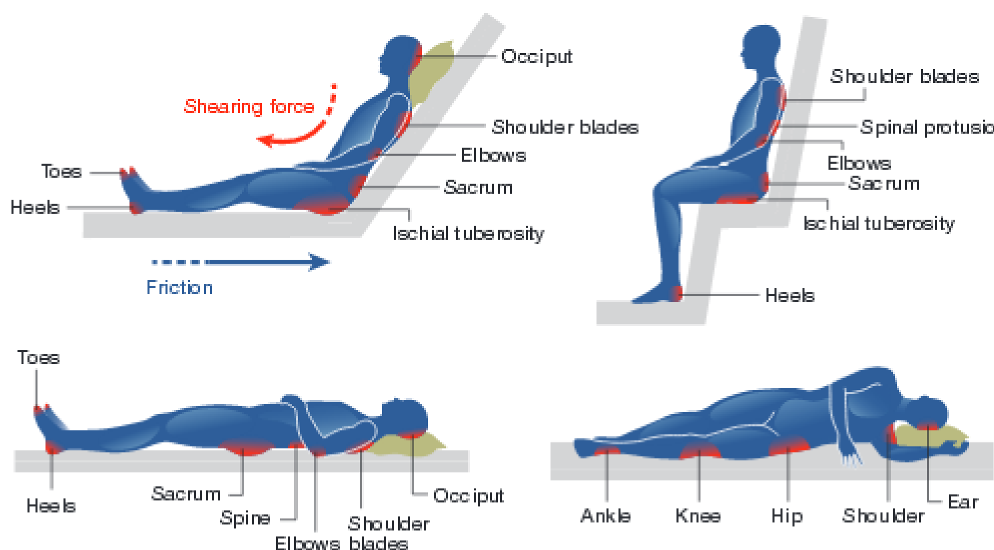
2.3 What are the early signs of a pressure ulcer?

You may notice the following signs of a pressure ulcer developing:

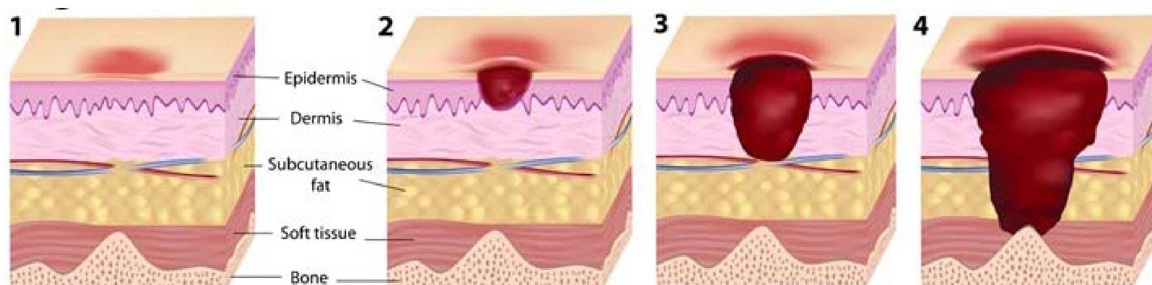
- Change in skin colour becoming redder or darker
- The area being hotter or colder than usual
- Discomfort or pain
- Blistering or swelling
- Skin damage.

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

2.4 Common locations of pressure ulcers



2.5 Categories of pressure ulcers



Category 1 Ulcers are the mildest. The upper layer of the skin will often be a reddish colour. Here the wound has not yet opened, but the extent of the condition is deeper than just the top of the skin. The affected area may be sore to touch but has no surface breaks or tears. The person may experience mild burning or itching and the skin does not turn pale when pressed firmly. The texture and temperature of this area will likely be different from the surrounding normal tissues.

Category 2 Ulcer may cause some pain. The sore area of the skin will have broken through the top layer and some of the layers below. The break typically creates a shallow, open wound and there may or may not be drainage from the area. It may appear as a serum-filled (clear to yellowish fluid) blister that may or may not have burst. The surrounding areas of the skin may be swollen, sore or red. This indicates some tissue damage.

Category 3 Ulcers will have broken completely through the top two layers of the skin and into the fatty tissue below. It may resemble a crater and could omit a bad smell. It is important to look for signs of infection including foul odour, pus and redness.

Category 4 Ulcers are the most serious and tend to extend below the subcutaneous fat into your deep tissues like muscle, tendons and ligaments. In more severe cases they can extend as far down as the cartilage or bone. There is a high risk of infection here. These sores can be extremely painful, and you can expect to see drainage, dead skin tissue, muscles and sometimes bone. The skin may turn black, exhibit common signs of infection, and there may be a dark, hard substance (hardened dead wound tissue) in the sore.

From the International Guidance on Pressure ulcers 2019 it is considered that the following definitions is included as Category 4 Ulcers. This is described as:

Unstageable: Depth Unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected Deep Tissue Injury: Depth Unknown

Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.'

Prevention & Treatment 3

3.1 What can be done to prevent pressure ulcers?

There are several ways that people can be supported to reduce the risk of pressure ulcers.

- **Keep moving**
  Changing the position regularly helps keep blood flowing. If there is reduced movement the health care team should assist with regular turns in addition to providing a specialist mattress, cushions and other equipment.

- **Look for signs of damage**
  Check the 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 the weight off it. If the skin looks damaged (is redder or darker than usual) change the position so that the person isn't lying on the skin. Also look out for blisters, dry patches or breaks in the skin.

- **Protect the skin**
  Encourage the person to wash their skin regularly using warm water and non-perfumed soap. If the person suffers from incontinence you will need to assess how best to support the person with this. Rubbing and massaging using a ring cushion is not recommended.

- **A well-balanced diet and fluid intake**
  Encourage the person a healthy balanced diet and drink plenty of fluids. Extra protein may help.

- **Discussions about risks**
  It is important that where an adult faces risks to their wellbeing because of a pressure ulcer that professionals discuss this with them. This may be particularly necessary where the adult is likely to self-neglect and is not following clinical advice which could adversely affect their skin care and health. Professionals need to outline the likely consequences to them about not following advice including care and treatment plans.

3.2 Talking to Adults with mental capacity about pressure ulcers

In all circumstances the care worker and/or professional should outline all available options to the adult, regarding care and or treatment of the pressure ulcer. Ideally professionals and practitioners should include the reasons why the adult does not want the care or treatment and discuss with them any other relevant or earlier decisions they took previously, when they faced other relevant or similar risks to their health. The discussion may include what the adult values most and how they are weighing the risks and possible consequences of not having the care or treatment.

Where the **adult has mental capacity** to decide about their health and wellbeing and they want to make an unwise decision, by not accepting the care or treatment then the carer and or professional needs to record the discussions and decision of the adult in full. If the organisation has a policy or procedure for supporting adults with decisions, this should be followed. Where the risks are high and organisational risk protocols are available, it is advisable to use this in order to escalate the matter to someone more senior for clinical advice and the person's GP may need to be contacted about the concerns for the adult.

3.2 Talking to Adults without mental capacity about pressure ulcers

In all circumstances the care worker and/or professional should outline all available options to the adult, regarding care and treatment of the pressure ulcer. Ideally professionals and practitioners should include the reasons why the adult does not want the care or treatment and discuss with them any other relevant or earlier decisions they took previously, when they faced other relevant or similar risks to their health. The discussion may include what the adult values most and how they are weighing the risks and possible consequences of not having the care or treatment.

Where the adult appears to **lack mental capacity** to decide about their health and wellbeing concerning the pressure care, then it is recommended that the person concerned with their welfare should assess their mental capacity. Where a care worker or professional works for an organisation and there is a mental capacity procedure or policy available this should be followed.

Where the adult has made an advanced decision to refuse the care or treatment this should be considered and used where relevant. Carers or professionals should check if there is a Lasting Power of Attorney (LPA) for health and welfare decisions who may be able to make the decision regarding treatment of the pressure ulcer. The

person would need to check whether the LPA could make the relevant decision and be assured that the LPA is registered with the Office of the Public Guardian (OPG), to make the decision on behalf of the adult. If the person is concerned that the LPA is not making the decision for the adult in their best interests, then they should notify the OPG and a Safeguarding Adult Concern should be raised.

Where there is no advanced decision to refuse medical treatment and no relevant LPA in place then the person who is concerned with the person's welfare would need to assess their mental capacity and make a best interest decision. This person would need to have full regard for the Mental Capacity Act 2005 and follow the best interest checklist outlined within the law. In such instances it would be useful to discuss with the person's family member, friend or advocate what the concerns are and the options for treatment.

3.3 Medical Photographs

The carer or professional most concerned with the adult's wellbeing may need to consider supporting the adult to make a decision by taking and then discussing a medical photograph with them. The person would need to either gather consent from the adult to take the photograph or make a best interest decision where the person lacks mental capacity about this. This would be especially helpful, if the adult cannot see and or feel the pressure ulcer and skin damage themselves. This additional information could support them to decide to agree to medical interventions or not.

3.4 What should I do if I suspect a pressure ulcer?

You should provide the appropriate advice to the patient. 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, self-neglect and in some cases domestic abuse. They can also develop due to poor diet, inadequate care and inappropriate physical handling. Pressure ulcers can be the result of the inappropriate or non-use of equipment. 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. Advice can be sought from a Tissue Viability Nurses, GP or District Nurses. Always make decisions based on sound professional judgement and seek the input of a clinician where needed.

3.5 Other Reading Resources

Professional and medical information on the identification, assessment and treatment of pressure ulcers can be found at the following links:

National Institute for Health Care Advice: Pressure ulcers, prevention and management:
https://pathways.nice.org.uk/pathways/pressure-ulcers#path=view%3A/pathways/pressure-ulcers/preventing-pressure-ulcers-in-adults.xml&content=view-index

NHS Information about pressure ulcer (sores):
https://www.nhs.uk/conditions/pressure-sores/

International Pressure Ulcer Guidelines:
https://www.internationalguideline.com/static/pdfs/Quick_Reference_Guide-10Mar2019.pdf

Pressure Ulcers & Safeguarding 4

Is there a safeguarding concern?

Concern is raised that a person has severe pressure damage

Category 3/4 unstageable suspected deep tissue injury or multiple sites Category 2 damage (refer to prevention and treatment guidelines)

Is it a Safeguarding concern?

If you have concerns seek clinical advice from a District Nurse/Tissue Viability Nurse, GP or other medical professional. As a guide a score of 15 or higher in the Decision Guide would indicate a safeguarding concern.

Discuss the concern with the adult or an appropriate advocate if required, explain the nature of the concern and establish what they want to be the outcome from any action you might take. Complete with them the Adult Safeguarding Decision Guide (see overleaf) and raise an incident immediately as per your organisation policy. Get consent and use medical photography if appropriate.

If yes:

- Discuss with the person involving, as appropriate and with consent, family and/or carers, and explain that there are safeguarding concerns.
- Refer to Local Authority using local procedure, with completed safeguarding pressure ulcer decision guide documentation
- Following local pressure ulcer reporting and investigating processes.
- Record decision in the person’s records.

If no:

- Discuss with the person, involving, as appropriate and with consent, family and/or carers, and explain why it does not meet criteria for raising a safeguarding concern with the Local Authority. Then emphasis the actions which will be taken.
- Action any other recommendations identified and put preventative/ management measures in place.
- Follow local pressure ulcer reporting and investigating processes.
- Record decision in the person’s records.

Adult Safeguarding Decision Guide for individuals with severe pressure ulcers

Adult's Name	
Adult's NHS Number	
Adult's Social Care Number (if known)	

	Risk Category	Level of Concern	Score	Evidence
1	Has the patient's skin deteriorated to either category 3/4/ unstageable or multiple category 2 from healthy unbroken skin since the last opportunity to assess/visit	Yes e.g. record of blanching / non-blanching erythema /category 2 progressing to category 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 (skin changes at life end), 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	5	What elements of care plan are in place

		reviewed as person's needs have changed		
		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	
		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 concern needs to be raised, the tool should be recorded in the patient’s notes.

Name of Assessing Nurse / Clinician / GP / Doctor	
Jon Title	
Signature	
Name is Second Assessor	
Job Title	
Signature	