Safeguarding Adults from Pressure Ulcers

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What we will cover

- Learning from when things go wrong
- Why do we all need to know about this
- What are pressure ulcers and MASD and shear tissue injury
- Risk Factors
- Relevant Law and Statutory Guidance
- Prevention is everyone's responsibility: assessment, information sharing, preventative equipment and preventative care planning

Learning When Things Go Wrong

Safeguarding Adults Reviews

Serious Incident Investigations

Patient Safety Incident Response Framework

Why We All Need to Know

- Legal and moral obligation to protect people at risk of pressure ulcers and Moisture Associated Skin Damage
- Article 2 Human Rights Act: Right to Life – public bodies have a positive duty to protect life
- Article 3 Human Rights Act: The right to freedom from torture and inhumane and degrading treatment
- Care Act 2014 – duty to promote wellbeing and prevent the development of needs, and reduce needs (s.1 and s.2)

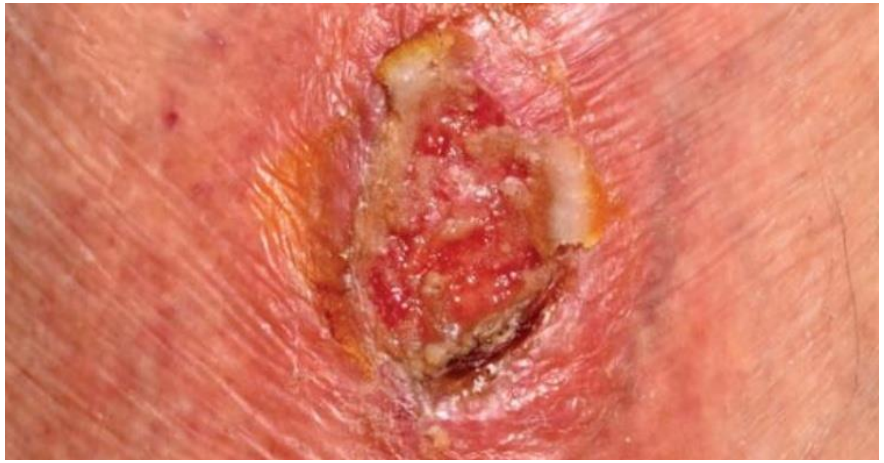
Why We All Need to Know

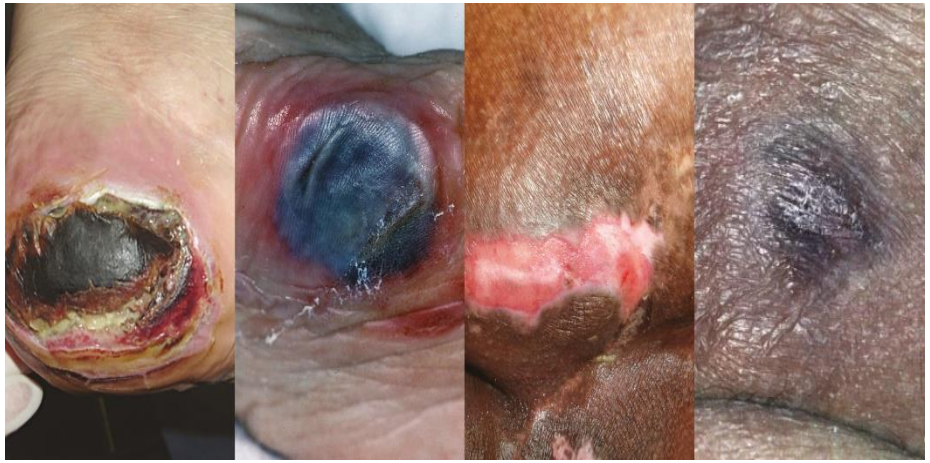
- Prevention of severe pain
- Prevention of life-threatening and debilitating infections
- Preventing hospitalisations and reducing duration of admissions
- Promotion of dignity and comfort
- Promoting quality of life
- Efficient use of resources

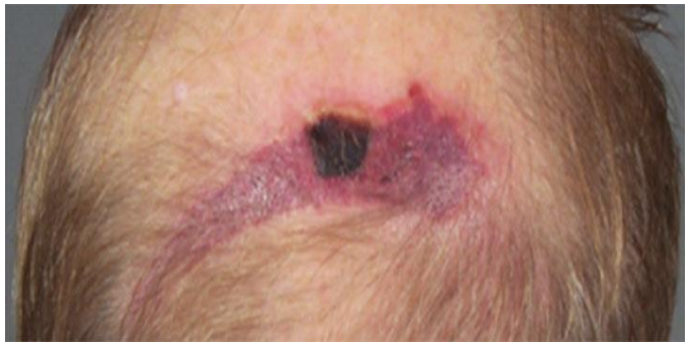
Pressure Ulcers and MASD

A pressure ulcer is a localized damage to the skin and/or underlying tissue usually over a bony prominence, (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear)

The damage can be present as intact skin or an open ulcer and maybe painful.







NHS
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Pressure Ulcer classification guide

All pressure ulcers category 1-4 (EPUAP 2014) and deep tissue injury must be reported as per Trust Guidance

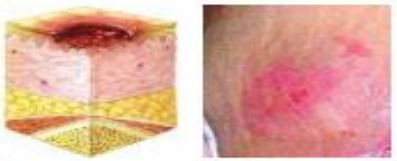
HARTMANN

Category 1

Non Blanchable erythema:

Intact skin with non-blanchable redness over a bony prominence. Dark coloured skin may not have visible blanching - this may present as a different colour to surrounding skin. Area may be painful, firm, soft, warmer or cooler to touch than surrounding skin.

Category 2

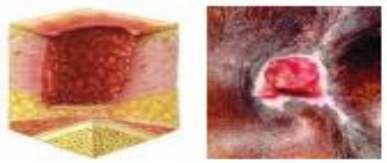


Partial thickness skin loss:

Partial thickness loss of dermis, presents as a shallow open ulcer without slough. May also present as an intact or open ruptured serum filled blister.

**Bruising indicates deep tissue injury*

Category 3



Full thickness tissue loss:

Subcutaneous fat may be visible but underlying structures (e.g. bone, tendon, muscle) are not visible. Slough may be present but does not obscure the depth of tissue loss. Depth may vary due to anatomical location. Undermining/ tunnelling may be present.

Category 4

Full thickness tissue loss:

Full thickness tissue loss with exposed structure (e.g. bone, tendon, muscle)

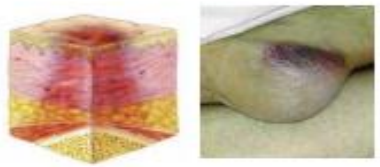
Slough or eschar may be present; often including undermining/tunnelling.
May vary due to anatomical location.

Unstageable/Depth unknown

Full thickness tissue loss in which the base of the ulcer is obscured by slough or necrosis. Until the base of the wound is exposed then the category cannot be determined. Note: stable, dry eschar (without fluctuance or erythema) serves as the body's natural cover and should not be removed.

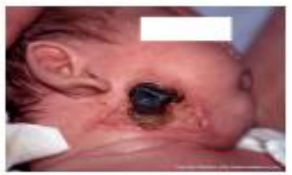
Deep tissue injury depth unknown (DTI)

Purple or maroon localised 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 with adjacent tissue. DTI may be difficult to detect in individuals with dark skin tone. Evolution may include a thin blister over a dark wound bed. The wound may evolve and become covered by a thin eschar.
Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



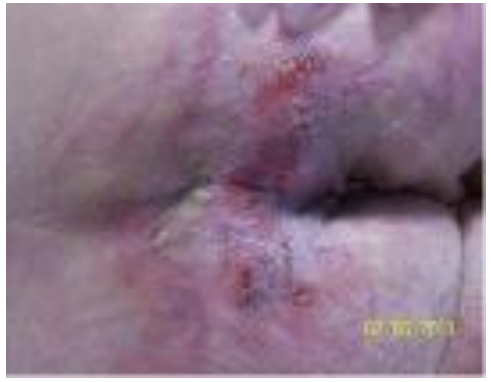
Medical Device Related

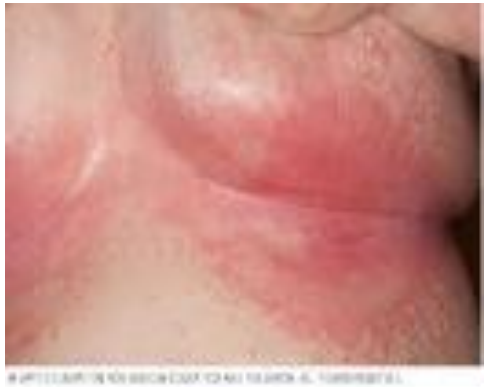
Device related pressure ulcers SHOULD be reported and identified by the notation of (d) after the category.- eg category 2 PU (d) to allow their accurate measurement



National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014. Images kindly used with permission by Medtec. Copyright Medetec (medetec.co.uk)

Moisture Associated Skin Damage VS Pressure Ulcers





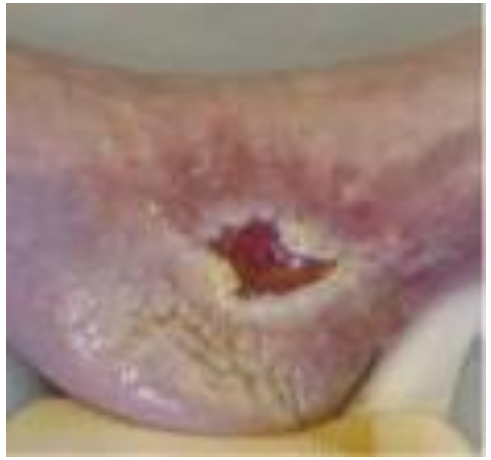


Table 1. Guide to pressure ulcers and moisture-associated skin damage (MASD)

	Pressure ulcer	MASD (inc. moisture lesion)
Cause	Pressure and/or shear forces Internal or external forces	Moisture (MASD): incontinence (incontinence-associated dermatitis), sweat (Intertriginous dermatitis), peristomal (stoma), periwound (wound exudate) and friction
Location	Usually bony prominences, occurring in a defined area	Sacrum, perineum, stoma, wounds edges, skin folds, any part of the body exposed to moisture
Depth	Superficial to full thickness	Superficial to partial thickness
Shape	Defined edges, often circular or regular shape	Diffuse area (moisture uncontained) 'Kissing' ulcers may be present
Necrosis	Possible necrosis	No necrosis
Colour of wound bed	Non-blanching erythema, slough, necrosis	Red, pink or white; not equal
Irregular ulcers	Irregular wound shapes are often present in both pressure ulcers and moisture lesions	Irregular wound shapes are often present in both pressure ulcers and moisture lesions

Risk Factors

Frailty	Reduced mobility	Incontinence	Reduced food and/or fluid intake
Elderly	Previous skin damage	Long stretches sitting or lying in one place	Sliding down chairs or beds

Relevant Law and Statutory Guidance

Safeguarding Adults Protocol: pressure ulcers and raising a safeguarding concern

The Care Act 2014 sections 7, 9 and 11

Care and Support Statutory Guidance, Chapter 6

Department of Health and Social Care Guidance

Safeguarding Adults Protocol: Pressure Ulcers and Raising a Safeguarding Concern

Foreword by Lynn Romeo, Chief Social Worker for Adults:

*While the treatment and response to pressure ulcers is predominantly a clinical one, the prevention of them - our ultimate goal - **is a shared responsibility**.*

*The reality is that **many people at risk of pressure ulcers** are receiving services that are commissioned, arranged and provided by non-clinical staff in the **social care sector**.*

*It is vital that **any assessment** addresses the **likelihood of pressure ulcers** developing and **what action must be taken to prevent them**.*

*Those responsible for carrying out assessments and arranging services need to be alert to this issue and have easy access to **clinical advice to support care planning**.*

Relevant Law and Statutory Guidance

Care Act 2014, Section 7 Duty to cooperate on specific cases

If a local authority requests co-operation of a health professionals, or other relevant professional, to help in the assessment or support of an individual with care and support needs, they must cooperate, unless it is incompatible with their own duties.

And vice versa.

Care Act 2014, Section 9 Assessment of an adult's needs for care and support

When an adult may have needs for care and support, the authority must assess the adult's needs.

The assessment **must involve** the **adult**, any **carer** that the adult has, and **any person whom** the adult suggests, or where the adult lacks capacity, **any person who appears to be interested** in the adult's welfare.

Care and Support Statutory Guidance Chapter 6

*6.14 Where an adult has **a need...** the local authority... must... consider whether their need(s) have... consequences on their... personal health.*

6.14 The local authority must also consider whether the individual's needs impact upon their wellbeing beyond the ways identified by the individual.

*6.77 Where **more than one agency** is assessing a person, they should all **work closely together** to prevent that person having to undergo a number of assessments at different times.*

*6.78 Where a person has **both health and care and support needs, local authorities and the NHS should work together** effectively to deliver a high quality, coordinated assessment.*

Safeguarding is Everyone's Responsibility

Best Practice in Information Sharing

- Accurate and timely information sharing is important - especially at points of transition
- Sharing information can be legally justified solely to prevent harm – you can override consent to prevent harm to someone
- If you determine someone lacks mental capacity to make a decision that could impact on their skin, share this with relevant professionals
- Share a person's or their family's concerns with relevant other agencies
- Don't assume other people know something that you know
- Don't leave people or families to share information themselves – take responsibility for communicating important information to others

Best Practice in Assessments and Reviews

- Multi disciplinary input – social workers, nurses, Ots, physiotherapists, and doctors need to speak to each other to inform assessments when both are involved
- Assess the likelihood of pressure ulcers developing – find out what specialist assessments have been undertaken e.g Purpose-T or Waterlow, or do them yourself
- Take into account previous harm to skin – check your understanding of clinical terminology you see on records
- Accurately document the information you have relied on and where it came from
- Share and reality check your conclusions with the other relevant professionals including those directly providing care
- Follow clinical guidelines when you are assessing a skin concern

Apply the Mental Capacity Act 2005 Correctly

- Know when to doubt capacity
- Undertake assessments of capacity thoroughly – it is more than a one off conversation
- Consider executive capacity – can someone really enact the decisions they tell you?
- You DO NOT need a diagnosis of mental disorder to doubt capacity nor to evidence that they lack it
- Best interests decisions must be made following the lawful process set out in section 4 – consult with relevant professionals, paid and unpaid carers, and the adult

Apply the Mental Capacity Act 2005

Best Interests Decisions Section 4

The decision maker must consider, where possible:

The person's past and present wishes and feelings

The beliefs and values that would be likely to influence their decision if they had capacity

Other factors they would be likely to consider if they were able to do so

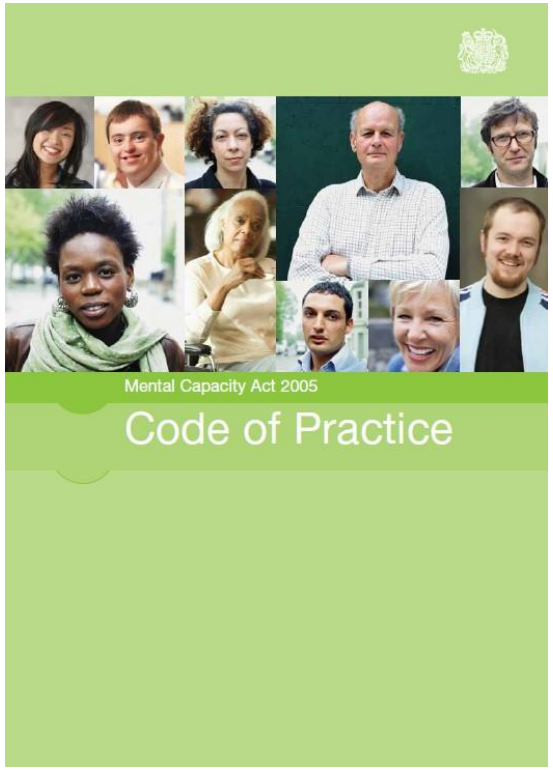
The decision maker must take into account the views of:

Anyone named by the person as someone to be consulted

Anyone engaged in caring for the person or interested in their welfare (this could be a paid or unpaid care provider and any relevant professionals)

Anyone holding of a lasting power of attorney of deputyship

When should we doubt capacity?



The Mental Capacity Act Code of Practice is the guidance that we all must follow.

It tells us how to understand and apply the Mental Capacity Act 2005.

- *If the person's* ***behaviour or circumstances cause doubt***
- *If somebody else says they are* ***concerned about the person's capacity***
- *If the person has* ***been diagnosed with an impairment or disturbance*** *affecting their mind or brain;* ***and*** *it has already been* ***shown they lack capacity to make other decisions*** *in their life.*

Preventative Equipment and Treatment

Acute TVN Team Hillingdon Hosp
Awareness Treatment Education

The Hillingdon Hospitals NHS
NHS Foundation Trust

Pressure Relieving Equipment

Dermis Plus – Silicone pads/ rolls used for preventative measures and therefore should be used on intact skin only. Can be used under equipment however should not be secured to the patients skin.

Repose heel protectors /wedge – designed to aid repositioning and offload pressure off the heels – Can be used on intact or broken skin (with a dressing in place). ** **NOT single patient use** **

- Air mattress - All patients with skin damage/ high risk/ reduced mobility/ amber or Red Purpose T.
- Aircushion – Patient's with existing skin damage/ high risk of skin damage of which are on an air mattress should have the corresponding mattress when sitting out in a chair.
- Sliding sheet's – eliminate friction/ force of manual handling and therefore remove the risk of ski damage secondary to sheering/friction.
- Dolphin Mattress – Fluid immersion therapy mattress for patient with chronic wounds in which continue to deteriorate despite Airflow therapy – can be used on end-of-life patients and to assist with pain management.
- Comfeel Hydrocolloids/ barrier products – Can be used in preventative measures underneath certain devices such as CPAP tubing/ on thighs to protect from catheter tubing if applicab

Barrier Creams/Sprays/Films

- **Barrier creams/Sticks/ Sprays** are used to protect intact skin, they form protective layers and help to prevent the skin from initial breakdown. Moisture from sweat, urine, or other contaminants **can** make skin more likely to tear or open. **Barrier creams** keep out these contaminants and reinforce the vulnerable skin

Preventative Care Planning

Use the information you have about risk to skin to inform a care plan or treatment plan

If someone cannot get out of bed alone, ensure care to manage risks from foreseeable incontinence or sustained pressure is arranged promptly

Consider the suitability of someone's accommodation if they do not have space for pressure relieving equipment – do they need a placement to manage the risk?

If you believe the care plan is not sufficient to manage the risks, raise this with whomever set it up. Do not leave it to the adult or family to do so. Do not wait for harm to occur.

If someone refuses or resists care that will manage the risk, this is a reason to doubt mental capacity

Questions