Island Wide Pressure Ulcer Prevention and Management Framework

July 2021

DOCUMENT PROFILE

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1. INTRODUCTION

This Framework has been developed to ensure an Island wide, standardised approach for the provision of care to those people who have or may be at risk of developing pressure ulcers and to ensure consideration is given where there are potential safeguarding concerns.

1.1 Pressure ulcers are a global concern. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day (NHS Improvement, 2018). In Jersey, our aim is to help prevent and reduce pressure ulcer development and associated complications, by working together to provide a framework that can be used across the Island by services that provide care to people who may be at risk of developing pressure ulcers.

1.2 This framework is designed to support a consistent and clear approach to prevention and management of pressure ulcers, across all settings and all age groups.

1.3 Each organisation, or service provider, will have specific policies and procedures in relation to personal care and risk assessment that reflect the principles of this framework. A holistic assessment or reassessment, that includes pressure ulcer risk assessment tools, will guide person-centred implementation of appropriate interventions to help reduce the incidence of, or deterioration in existing, pressure ulcers.

1.4 The framework supports delivery of person centred, optimal care standards by all health and social care providers, to prevent pressure ulcers and guide measurement for improvement.

(Aligns to Healthcare Improvement Scotland (HIS) Standards: 1,2,3,4,5,6 and Jersey Care Commission (JCC) Standards for Care Homes and Homecare:1,2,5) (Appendix 1)

2. SCOPE

2.1 The prevention and management of pressure ulcers is an Island wide priority. This Framework applies to employees and carers working for on-Island organisations, public, private and voluntary, responsible for the care of people who may at risk of developing pressure ulcers.

2.2 A collaborative approach, working within the principles of this framework and in conjunction with JCC and HIS standards, will ensure consistent delivery of best practice, ensuring inclusion of the person at risk in the decision making process.

(Aligns to HIS Standards: 1, 2, 5, 6 and JCC Standards for Care Homes and Homecare 1, 2, 5).

3. PURPOSE

3.1 The framework aims to promote a collaborative approach to prevention and management of pressure ulcers, in all health and social care settings, by adopting a standardised approach based on best practice and evidence to:

- raise awareness of risks associated with pressure ulcers
- reduce risk of developing pressure ulcers
- increase knowledge and understanding of potential causes, preventative interventions and identification of pressure ulcers
- improve / drive delivery of high quality care by shared learning from incidents and positive experiences
- raise concerns where safeguarding issues are identified

3.2 This framework supports the individual's right to prevent and manage pressure ulcers in alignment with recommendations for best practice (HIS, 2020 and JCC Standards for Care Homes and Homecare 2019) (Appendix 1)

4. DEFINITIONS

4.1 For the purpose of this framework, the term "all age groups" includes:

- adults
- neonates
- infants,
- children
- young people

4.2 A pressure ulcer is defined as localised 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 and/or friction). The damage can present as intact skin or an open injury and may be painful. A pressure ulcer that has developed at the end of life due to skin failure is no longer referred to as a 'Kennedy Ulcer' and should be classified in the same way as all other pressure injuries. (NHSI, 2018)

4.3 Pressure ulcer categorisation is defined by NHSI (2019) (Appendix 2)

4.4 The definition of a pressure ulcer on admission (POA) should be that it is observed during the skin assessment undertaken **within** 6 hours of admission to an inpatient service or at first visit from Community Nursing Service.

4.5 The definition of a new pressure ulcer within a setting is that it is first observed **after** 6 hours of admission and within the current episode of care.

5. ROLES AND RESPONSIBILITIES

5.1 All health and social care providers across the Island will work together to ensure quality of care is maintained and improved through this framework.

5.2 All health and social care providers are responsible for seeking organisational support for the principles of this framework and the implementation of the recommendations.

6. PREVENTION AND MANGEMENT OF PRESSURE ULCERS

6.1 Prevalence

6.1.1 Despite raising public and professional awareness through national and local initiatives, prevalence remains a concern.

6.1.2 NHS Improvement have recognised that systems used to monitor and report pressure ulcers at local, regional and national levels are not standardised and as a result issued the revised definition and measurement document for pressure ulcers in 2018. This framework aligns itself to these recommendations.

(Aligns to HIS Standards: 1, 2 and JCC Standards for Care Homes 12 and Homecare 9)

6.2 Measurement for Improvement

6.2.1 It is vital that processes as well as outcomes are measured to ensure an understanding of which part of the process needs strengthening in terms of reliability.

6.2.2 Examples of outcome measures:

- number of new pressure ulcers;
- location of the individual when the pressure injury was identified i.e. home, hospital, other care setting
- category of pressure ulcer;
- rate of occurrence of new pressure ulcers per 1,000 bed days
- rate of occurrence of new pressure ulcers per caseload

6.2.3 Organisations should decide what outcome measures are most appropriate and relevant to their care settings and all relevant information should be shared with all staff at team level in order to drive improvement.

6.2.4 Examples of process measures:

- percent (%) compliance with risk assessment within an agreed period since admission to service
- level of compliance with SSKIN / aSSSKINg bundle (Appendix 3)

  (Aligns to Healthcare Improvement Scotland Standards: 1, 2 &Jersey Care Commission Standards for Care Homes 12 and Homecare 9)

6.3 Causes of pressure ulcers

6.3.1 Pressure ulcers can affect anyone. Risk factors include age, medication, long lie, trauma, incontinence and pain (NHSI Core Curriculum, 2019)

6.3.2 The factors causing pressure injuries are divided into two groups:

1. Intrinsic – including disease, medication, malnourishment, age, dehydration/fluid status, lack of mobility, incontinence, skin condition and weight:

2. Extrinsic – external influences, which cause skin distortion including pressure and shearing forces.

6.3.3 Pressure ulceration to the foot of a service user has not always been recognised and reported. A number of these may be classified as device related pressure ulcers e.g. footwear or plaster casts.

6.3.4 NHS Improvement (2018) have recommended that the terms ‘avoidable’ and ‘unavoidable’ no longer be used.

(Aligns to HIS Standards: 1,2,3,4 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4)

6.4 Prevention of pressure ulceration

6.4.1 Each organisation has a responsibility to demonstrate leadership and commitment to the prevention and management of pressure ulcers.

6.4.2 For the prevention and management of pressure ulcers, the organisation can demonstrate:

- implementation of policies, procedures, guidance and standards
- a multi-professional approach
- facilitation cross-organisational support

- collection, monitoring, review and action on data
- ongoing quality improvement
- adherence to Duty of Candour
- there is timely, effective, and person-centred communication, documentation and transfer of information to ensure continuity of care between teams and settings.

  (Aligns to HIS Standards: 3, 4, 5, 6 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4, 5)

6.5 Assessment of risk of developing a pressure injury.

6.5.1 An initial risk assessment is undertaken as part of admission to a care setting and informs care planning.

6.5.2 Pressure ulcers can develop and deteriorate quickly, particularly in people considered to be at high risk, for example:

- neonates
- people with frailty
- those with limited mobility
- those with diabetes,
- those who are nutritionally compromised
- those at end of life

6.5.3 A risk assessment tool is used to support professional or clinical judgement.

6.5.4 Assessment and documentation of the risk of developing pressure ulcers or further damage to existing pressure ulcers is:

- within 6 hours of admission to hospital or care home
- within 24 hours of admission to any other care setting
- on the first visit from community services or teams, for example, community nurse, hospital at home, social care or care at home

6.5.5 There are requirements for ‘valid consent’. For consent to be valid, it must be:

- given by a person with capacity to consent or refuse consent to the intervention in question, or any other legal decision maker
- given voluntarily and freely, without pressure or undue influence being exerted on the patient either to accept or refuse treatment

- based on appropriate information and understood (informed). Acquiescence where the patient does not know what the intervention involves, is not consent

6.5.6 The Capacity and Self-Determination Law enshrines in legislation, a personal autonomy and right to choose for themselves. There can be circumstances where a person may refuse part of, or all treatments. Where this occurs, it is important to spend time with the person, examining their views, whist given them appropriate information about the foreseeable consequences of deciding one way, or another or not deciding to take treatment at all.

(Aligns to HIS Standards: 3,4,5,6 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4, 5)

6.5.7 In the circumstances of a capacious refusal or care and treatment, the recording must include details of the information given to the patient, including the information regarding outcomes of refusing intervention. The recording must also contain details of the person's understanding and retention of the given information about treatments(s), and how they used the information in making their decision to refuse treatment. A 'Decision-Making Record' can be extremely helpful in these circumstances.

6.5.8 Each formal assessment is undertaken by appropriately trained staff and includes:

- with valid consent, inspection of the person's skin, particularly areas over bony prominences and areas in contact with equipment and devices - careful attention is paid to those individuals with darkly pigmented skin in order to identify early skin damage

- assessment of risk factors and other contributing factors, for example people with frailty, pain, limited mobility or diabetes, and those who are nutritionally compromised, or at end of life

- assessment of the person's needs within their home or care setting, including positioning and equipment

- planned review of care plans and reassessment of risk

Where an assessment of risk or skin inspection has not been undertaken within the agreed time frames, staff record within the person's care plan:

- the reason, or reasons, assessment or inspection has not been undertaken or was delayed

- the discussion with the person

6.6 Re-Assessment of Risk

6.6.1 Regular reassessment is used to evaluate an individual's risk of developing a pressure ulcer, or experiencing further damage to an existing pressure ulcer(s).

6.6.2 Risk reassessment ensures that any changes in a person's circumstances, for example if the person becomes acutely unwell, has a fall, undergoes an operation or their mobility is reduced, are recorded and used to inform care plans.

6.6.3 Regular review also ensures that an individual's care plan is safe, effective and person-centred.

6.6.4 Reassessment, undertaken alongside the evaluation of existing care plans, also identifies whether existing interventions are managing the risk appropriately.

6.6.5 A reassessment of risk is undertaken and existing care plans are evaluated and revised when:

- an observed or reported change has occurred in the person's condition or changes noted on skin inspection
- the person (and/or carer) report a change
- the person is transferred to another care setting
- the person is transferred between clinical areas e.g. transferring care between wards
- when the person is discharged from one care setting and receiving care setting is provided with current assessment
- according to organisational guidance

  (Aligns to HIS Standards: 4, 5, 6 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4, 5)

6.7 Implementation of prevention, treatment and care plans

6.7.1 A Person-Centred Care Plan will be developed and implemented to reduce the risk of developing pressure ulcer(s) and to manage any existing pressure ulcer(s).

6.7.2 Preventative strategies such as the SSKIN / aSSSKINg care bundle (Appendix 3) should be initiated where a person is at risk of developing a pressure ulcer or to prevent further deterioration of an existing pressure ulcer(s).This should also include engagement with and support of the person and care providers, where indicated to self-manage their risk of developing pressure ulcers.

6.7.3 Where a care plan has not been implemented or followed, there should be documented explanation in their record and the reason care has not been delivered; e.g., it is their choice, where there is no access to specific services and evidence of the discussion with the person and any agreed actions.

6.7.4 Healthcare providers implement organisational policies and processes to deliver safe, effective and person-centred care. This includes criteria and timings for referral or liaison with specialist teams such as:

- podiatry
- dietetics
- tissue viability service
- vascular service
- occupational therapy
- physiotherapy
- pain management services

6.7.5 The care plan is agreed with the person and includes:

- the outcome from the risk assessment and skin inspection identification and management of other risks or contributing factors, including, pain, skin tone, incontinence, nutritional compromise (SSKIN / aSSSKINg bundle)
- a treatment plan for any existing pressure ulcer(s)
- frequency of repositioning
- requirements for equipment
- skin cleansing and maintenance regime
- details of self-management strategies and information
- planned reassessment of risk and care plan

6.7.6 The person-centred care plan is:

- reviewed to ensure it meets the ongoing needs of the person
- fully implemented and used to inform handovers, care transitions and discharge planning

  (Aligns to HIS Standards: 3,4,5,6 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4, 5)

6.8 Categorising and care planning for identified pressure ulcers

6.8.1 People with an identified pressure ulcer(s) will receive a person-centred assessment, a categorisation of the pressure ulcer(s), comprehensive wound assessment and an individualised care plan.

6.8.2 Regular review is required to monitor the person's condition, reduce the risk of deterioration in any identified pressure ulcer(s) and to help identify infection or sepsis.

6.8.3 Pressure ulcers categorised as 2 and above are reported using an organisational reporting system. (Please see statutory reporting section)

(Aligns to HIS Standards: 2, 5, 6 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4, 5)

6.9 Dressing Formulary

6.9.1 The Dressing Formulary, intended to promote standardised selection of dressings across the Island is managed by the TVNs, and based on contemporary, evidence based, best practice guidance.

6.9.2 The type of dressing selected to promote healing of a pressure injury should be discussed with the individual and their family or carers, if appropriate.

(Aligns to HIS Standards: 5, 6 & JCC Standards for Care Homes and Homecare 6)

6.10 Debridement

6.10.1 If autolytic debridement is likely to take longer and prolong healing time, then the utilisation of conservative sharp debridement by a competent practitioner, such as a suitably trained and qualified TVNS, may be considered (NICE 2014). Each organisation will be responsible for policy development within their clinical area and ensure adherence to organisational guidelines for practice, including timely and appropriate referral to hospital from the community as and when required.

(Aligns to HIS Standards: 1, 2, 6 & JCC Standards for Care Homes and Homecare 6, HCS Conservative Sharp Debridement Policy 2021, FNHC Debridement Policy)

6.11 Discharge

6.11.1 All incidences of damage to skin integrity must be communicated to receiving providers of care on discharge or transfer and supported with documentation to ensure continuity between care settings and agencies. Communication should take place prior to discharge and include any need for specialist services, equipment or dressings.

(Aligns to HIS Standards: 1, 3, 5 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4, 5)

6.12 Access to specialist equipment

6.12.1 People identified with an existing pressure ulcer or at significant risk of developing pressure ulceration, should be cared for on a pressure redistribution surface according to the holistic, risk assessment

6.12.2 Every care setting, should provide a basic level of equipment for the prevention of pressure ulcers for individuals, with the exception of custom made items. This includes; pressure redistributing cushions, heel and joint protectors and pressure redistributing mattresses. Maintenance of equipment is the responsibility of the care setting and should be carried out according to manufacturer's guidelines.

6.12.3 For those individuals with capacity, fully informed of the risk, yet declining to purchase any recommended specialist equipment, when for use in their own homes, their decisions must be documented.

(Aligns to HIS Standards: 1,2,3,5 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4, 5)

6.13 Reporting

6.13.1 All pressure ulcers, irrespective of category, should be recorded in the individual's record. All pressure ulcers Category 2 and above, including suspected Deep Tissue Injury (sDTI) and unstageable pressure ulcers, should be reported into the organisation reporting system.

6.13.2 Pressure ulceration is considered as harm to people and therefore should be reported as an individual safety incident within the organisational risk management, reporting and learning system.

6.13.3 All POA (Pressure injury On Admission) category 2 or above should be reported in organisational reporting and learning systems.

6.13.4 All Medical Device Related Pressure Ulcers (MDRPU) should be reported and identified by using the appropriate category e.g. category 3 (MDRPU).

6.13.5 Moisture Associated Skin Damage (MASD) should be reported in local systems. Where skin damage is caused by a combination of moisture and pressure, the damage will be recorded as the category of pressure ulcer.

6.13.6 Care settings that are registered with the Jersey Care Commission have a statutory duty to notify the Commission of any pressure ulcers, Category 2 and above. The notification form is a requirement of compliance with registration in these settings (Appendix 4)

6.13.7 Pressure ulcers, category 2 or above, that are thought to have been sustained in a care setting including hospital, hospice, prison, residential, nursing or other care setting, a Pressure Ulcer Specific Root Cause Analysis (RCA) tool should be completed by a Registered Nurse / Manager and reported within the organisations quality assurance process to support individual and organisational learning (Example hospital RCA given in Appendix 5)

6.13.8 For pressure ulcers, category 2 or above, that are thought to have been sustained in the person's home where they are in receipt of nursing or social care at home. An RCA should be completed by a registered nurse / manager and reported in the organisations quality assurance process to support individual and organisational learning.

6.13.9 It is essential to identify incidents that indicate the most significant opportunities for learning and prevention of future harm.

6.13.10 If there are clusters of incidents, such as falls, pressure sores etc, investigating each individually using a full root cause analysis framework could lead to a debilitating process which does not support effective learning.

(Aligns to HIS Standards: 1, 2, 3, 4 & 7 & JCC Standards for Care Homes 12 and Homecare 9)

7 SAFEGUARDING

7.1.1 Safeguarding is everyone's business and in its broadest terms, abuse can happen to anyone, anywhere. Responsibility for dealing with it lies with us all as members of the public, volunteers and professionals. It is, therefore, the responsibility of all staff to follow this framework and ensure referrals to Adult Safeguarding and Children and Families Hub are completed in a timely manner.

7.1.2 This policy should be read alongside the Jersey Safeguarding Partnership Board's (SPB) procedures, additionally any relevant single agency policies.

7.1.3 Building relationships is key to achieving person-led, outcome-focused decisions that enhance the person's involvement in decision making and optimises their choice and control. However this should not be a barrier to effective safeguarding when considering the wider risk to others. Please see Making Safeguarding Personal. (Appendix 7)

7.1.6 Pressure ulceration may be an indication that a person is being neglected; neglect may involve deliberate withholding or unintentional failure of a carer to provide appropriate and adequate care and support. This may result in, significant preventable skin damage.

7.1.8 All health and social care providers are required to raise concerns around safeguarding. See Appendix 8 for the relevant pathway for specific areas to identify those pressure ulcers that need to be referred into the Safeguarding Alert

Process or those that can be managed within standard governance processes. Please include the adult decision guide once completed with the SPOR referral. If there are any concerns please discuss with the health Safeguarding Team.

7.1.9 A minority of cases may warrant raising a safeguarding concern. Adults should be referred to the Adult Safeguarding Team 01534 444440 or where a child is concerned, with the Children and Families Hub 01534 519000. The individual should be made aware they are being referred unless there is an identified reason not to share this with them such as lack of capacity in this area.

(Aligns to HIS Standards: 1, 2, 3 & 4, JCC Standards for Care Homes 4,6,7,9,10,11,12 and Homecare 3, 4, 5, 6, 7, 8, 9)

8 EDUCATION, TRAINING and INFORMATION

8.1 Ensuring staff are competent and confident to deliver safe and high quality care remains a key requirement for all health and social care providers. This framework supports the standards for education, training and information as described in Health Care Improvement Scotland (2019) (Appendix 1)

8.2 Each Organisation will demonstrate commitment to the education and training of staff involved in the prevention and management of pressure ulcers, appropriate to roles and workplace setting. The NHSI Core Curriculum (2018) should be used to guide content.

8.3 Information and support is available for anyone at risk of developing, or identified with, a pressure ulcer.

8.4 At community level, there are a number of individuals who may be at risk of pressure ulceration but only have contact with health professionals through their General Practitioner and Practice Nurses. Primary Care Services must have mechanisms in place to educate primary care staff in relation to this framework and to engage with individuals about the importance of skin checks and caring for their skin.

8.5 The framework supports a collaborative approach to on-going training across all health and social care provider organisations and encourages organisations to enable access to training sessions for staff regardless of their employing organisation.

9. CONSULTATION

9.1 This framework will be shared with all stakeholders in the Pressure Ulcer Taskforce Group for consensus.

9.2 Consultation Schedule

Name	Job Title	Organisation	Date
Rose Naylor	Chief Nurse	Health & Community Services	27th March 2020
Aisling Adams	Senior Nurse-Quality & Practice Assurance	Health & Community Services	27th March 2020
Becky Sherrington	Associate Chief Nurse	Health & Community Services	27th March 2020
Carole Brett	Tissue Viability Nurse	Health Community Services	27th March 2020
Tia Hall	Operational Lead for Adult Services	Family Nursing & Home Care	27th March 2020
Gilly Glendewar	Tissue Viability Nurse	Family Nursing & Home Care	27th March 2020
Hilary Hopkins	Head of Governance	Jersey Hospice Care	27th March 2020
Cheryl Keneely	Chair Person	Care Federation	27th March 2020
Sam Lempriere	Informatics	Health & Community Services	27th March 2020
Paul Ahier	Informatics	Health & Community Services	27th March 2020
Emma O'Connor	Patient Safety Officer	Health & Community Services	27th March 2020
Tim Hill	Practice Development	Health & Community Services	27th March 2020
Jessie Marshall	Lead Nurse-Secondary Scheduled care	Health & Community Services	27th March 2020
Claire Sambridge	Lead Nurse-Primary, Preventative	Health & Community Services	27th March 2020
Paul McCabe	Chief Pharmacist	Health & Community Services	27th March 2020
Mary Munns	Adult Safeguarding-Team Leader	Health & Community Services	27th March 2020
Patricia Marius	Interim Designated Safeguarding Lead	Health & Community Services	27th March 2020
Claire Thompson	Safeguarding Named Nurse for Adults	Health & Community Services	27th March 2020

Jenny Querns	Safeguarding Lead Nurse for Adults and Children	Family Nursing & Home Care	27th March 2020
Geoff White	Associate Chief Nurse	Health & Community Services	27th March 2020
Pam le Sueur		Health & Community Services	24th August 2020
Wendy Baugh	Lead nurse	Health & Community Services	23rd October 2020
Valter Fernandes	Lead nurse	Health & Community Services	23rd October 2020
Alex Watts	Lead Nurse	Health & Community Services	23rd October 2020
Jan Auffret	Lead Midwife	Health & Community Services	23rd October 2020
Ward managers	Grade 6 and 5 managers	Health & Community Services	23rd October 2020
Tarina Le Duc	Head of Quality and Safety	Health & Community Services	29th October 2020

10 RECOMMENDATION AND APPROVAL PROCESS

10.1 This framework provides a standardised approach for provision of care to those people who may be at risk of developing pressure ulcers. The Chief Nurse Group in conjunction with Health and Community Services, Family Nursing and Home Care and Jersey Hospice Care will maintain oversight of this framework through the Pressure Ulcer Taskforce Group

10.2 This policy is ratified by the Organisations Policy and Procedure Ratifying Group.

11 COMMUNICATION / DISSEMINATION

11.1 Public Engagement

11.1.1 The risk of sustaining pressure ulceration is often seen to be the problem of the health or social care professional; however, the individual at risk is central to successful prevention. Using the principles of adult safeguarding, ‘Empowerment, Prevention, Protection, Partnership, Proportionality and Accountability’ the desires and wishes of the individual should be considered.

11.1.2 This is particularly important when individuals suffer a life-changing event or illness that significantly increases their risk of being susceptible to pressure ulceration. Consideration must be given to the application of the Capacity and Self-Determination (Jersey) Law 2016. If the individual has capacity, it is important to work with them to highlight the risk and identify actions that can reduce the risk.

Consideration for a referral to Adult Safeguarding should be undertaken if the individual is self-neglecting to the point where harm is occurring. If the individual lacks capacity, best interest decision making will be required.

11.1.3 It is recognised that a true partnership involves more than just giving information. Individuals should be able to access information easily and be provided with the tools to help them assess their own risk of developing pressure ulcers, how to prevent them and who to contact should they be concerned.

11.1.4 If the individual lacks decision-specific capacity and continues to be non-concordant in the delivery of treatment; legal advice should be sought and consideration for an application to the court for protection may be required. All organisations should have clear processes in place to manage this.

11.1.5 All provider organisations should ensure that they can access a broad range of information and tools for individuals in order to encourage and support their participation in the prevention and management of pressure ulceration. All information should be culture and language specific.

(Aligns to: HIS Standards: 1, 2 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4,

11.2 Communications

11.2.1 In order to engage with the wider audience of services caring for those at risk the framework will be shared Island wide and to the general public via the GOV.JE website. There is an annual ‘Stop the Pressure Day’ which will include raising awareness of this framework.

(Aligns to HIS Standards: 1, 2 & JCC Standards for Care Homes and Homecare 7)

12 IMPLEMENTATION

12.1 This framework provides clear vision and standards that are understandable for both commissioners and providers of care. Successful implementation will require an Island Wide commitment with a common sense of purpose and a shared goal of harm free care. It is expected that all providers will adopt this framework.

(Aligns to HIS Standards: 1, 2, 3,4,5,6 & JCC Standards for Care Homes and Homecare 1, 2, 3, 4, 5)

13 MONITORING COMPLIANCE AND EFFECTIVENESS OF THE DOCUMENT

13.1 Each organisation will have audit in place for monitoring compliance with the pressure ulcer prevention strategies within this framework.

13.2 Any areas of concern identified, will result in the requirement for an improvement plan to be implemented and evaluated at next audit.

13.3 The Tissue Viability Nurses will continue to monitor and review the framework and report to their line managers

14 DOCUMENT REVIEW, FREQUENCY AND VERSION CONTROL

14.1 This document will be reviewed every two years, to take account of any changes in national guidance. Necessary changes throughout the year will be issued as amendments to the framework. Such amendments will be clearly identifiable as to which section they refer and the date issued. These will be clearly communicated to all service providers.

15 REFERENCES

European Pressure Ulcer Advisory Panel Prevention and Treatment of Pressure Ulcer: Clinical Practice Guideline 2014

Health and Community Services Jersey (2017) Policy and Procedure for the Management of Serious Incidents within Health and Social Services link: https://soj/depts/HSS/Registered%20Documents/P%20Serious%20Incident%20Policy.pdf#search=SI

Healthcare Improvement Scotland (2020) http://www.healthcareimprovementscotland.org/our work/standards and guidelines/stnds/pressure ulcer standards.aspx

Jersey Care Commission Home Care Standards (2019) link:

https://carecommission.je/wp-content/uploads/2019/02/JCC-Care-Standards-Home-Care-2019-v1..pdf

Jersey Care Commission Care Homes Standards (2019) link:

https://carecommission.je/wp-content/uploads/2019/08/JCC-Care-Standards-Care-Homes-Adults-2019v2.pdf

Jersey Safeguarding Board

(https://safeguarding.je/wp-content/uploads/2018/03/2018-MOU-amended-final.pdf)

NHS Improvement, pressure ulcers: revised definition and measurement, summary and recommendations. June 2018.

NHSI Core Curriculum, 2018. NHS Improvement (2018) *Pressure Ulcer Core*

Curriculum. Bit.ly/NHSIPUCoreCurriculum

National Pressure Ulcer Advisory Panel's (NPUAP) 2015

Ousey K, Chadwick P and Cook L (2011) Diabetic foot or pressure ulcer on the foot? Wounds UK, Vol 7, No 3

Phister HR and Bohm G (2008). The Multiplicity of Emotions: A framework for emotional functions in decision making. Judgment and Decision making, 3, pp 5 – 17.

Vowden P, Vowden K (2015) Diabetic foot ulcer or pressure ulcer? That is the question. TheDiabetic Foot Journal 18: 62-

16. APPENDICIES

Appendix 1: Summary of Healthcare Improvement Scotland Standards 2020

Summary of standards

- **Standard 1: leadership and governance**
  The Organisation demonstrates leadership in the prevention and management of pressure ulcers.
- **Standard 2: staff education and training**
  The Organisation demonstrates commitment to the education and training of all staff involved in the prevention and management of pressure ulcers, appropriate to roles and workplace setting.
- **Standard 3: person-centered information and support**
  Information and support is available for people with, or at risk of developing, pressure ulcers, and/or their representatives where appropriate.
- **Standard 4: initial assessment of risk of developing a pressure ulcer**
  An initial risk assessment is undertaken as part of admission to, or first contact with, a care service to inform care planning.
- **Standard 5: reassessment of risk**
  Regular reassessment is used to re-evaluate an individual's risk of developing pressure ulcers or experiencing further damage to existing pressure ulcers.
- **Standard 6: care planning for prevention of pressure ulcers**
  A person-centered care plan is developed and implemented to reduce the risk of developing pressure ulcers.
- **Standard 7: assessment, grading and care planning for identified pressure ulcers.**
  People with identified pressure ulcers will receive a holistic assessment and experience high quality and person-centered treatment and support

Hyperlink for full Standards:

https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx

The Jersey Care Commission Care Home Standards:

- You will be given information that is shared in a way that you understand. This will tell you and others about the service and how you will be cared for.
- You will be cared for and helped in a way which has been planned with you.
- You will be cared for and helped by the right people with the right values, attitudes, understanding and training.
- You will feel safe.

- You will be supported to make your own decisions and you will receive care and support which respects your lifestyle, wishes and preferences.
- Your care will be provided with consistency by competent care and support workers who have the necessary training and qualifications to meet your needs.
- The environment will enhance your quality of life and the accommodation will be a pleasant place to live or stay.
- Your meals will be varied, healthy and tasty and will be based around your preferences and requirements.
- You won't have to give up activities you enjoy when you live or stay in a care setting. There will be a range of things to do which will reflect your preferences and lifestyle.
- Yours and other people's thoughts, worries and complaints about how you are cared for will listened to and taken seriously.
- The care service will be well managed.
- The care service will be checked and reviewed regularly to sort out any issues and make things better for you and others

The Jersey Care Commission Homecare Standards:

1. You will be given information that is shared in a way that you understand. This will tell you and others about the service and how you will be cared for.
2. You will be cared for and helped in a way which has been planned with you.
3. You will be cared for and helped by the right people with the right values, attitudes, understanding and training.
4. You will feel safe.
5. You will be supported to make your own decisions and you will receive care and support which respects your lifestyle, wishes and preferences.
6. Your care will be provided with consistency and reliability by competent care and support workers who have the necessary training and qualifications to meet your needs.
7. Yours and other people's thoughts, worries and complaints about how you are cared for will be listened to and taken seriously.
8. The home care service will be well managed.
9. The care service will be checked and reviewed regularly to sort out any issues and make things better for you and others.

Jersey Care Commission Home Care Standards (2019) link:
https://carecommission.je/wp-content/uploads/2019/02/JCC-Care-Standards-Home-Care-2019-v1..pdf

Jersey Care Commission Care Homes Standards (2019) link:
https://carecommission.je/wp-content/uploads/2019/08/JCC-Care-Standards-Care-Homes-Adults-2019v2.pdf

Appendix 2: Categories of pressure ulcer

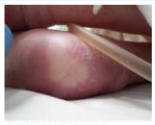
Pressure ulcer categorisation

NHS

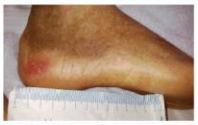
Blanching erythema

Healthy skin may develop transient redness when subjected to pressure – for example, if the legs are crossed. To test if damage has occurred, light finger pressure should be applied to see if the skin blanches (goes white). In darker skin tones, redness may present as a darker area that is grey or purplish. This is **not** a pressure ulcer.

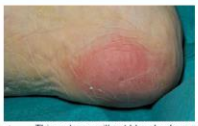
Example of skin blanch



Blanch in darker skin



This redness is persistent and does not blanch



This redness will not blanch when pressure is applied

Category 1: Non-blanchable erythema

Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

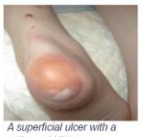
Category 2: Partial thickness skin loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

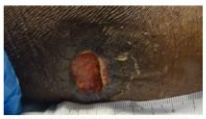
**Bruising indicates suspected deep tissue injury.*

An intact serum-filled blister

A shallow open ulcer with a red pink wound bed without slough



A superficial ulcer with a collapsed blister



Full thickness tissue loss. Subcutaneous fat is visible but no bone, tendon or muscle

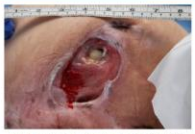
Category 3: Full thickness skin loss

Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.

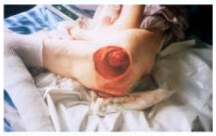
May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Category 4: Full thickness tissue loss

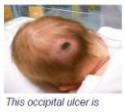
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (eg fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.



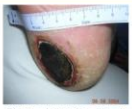
In this wound, the bone is clearly visible



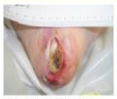
This wound shows exposed muscle



This occipital ulcer is covered by softening necrosis



This heel ulcer is covered by hard dry eschar



The necrotic cap on this heel has softened and started to separate

Although still firmly attached, there is a ring of demarcation where this eschar has been rehydrated

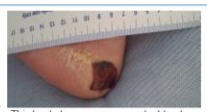
Unstageable: depth unknown

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.

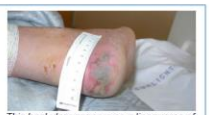
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected deep tissue injury: depth unknown

Purple or maroon 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 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.



This heel ulcer appears as a dry blood blister



This heel ulcer appears as a linear area of deep purple black discolouration

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To cite this poster please use: NHS Improvement Pressure ulcer categorisation group (2019) Pressure Ulcer Categorisation. Available from http://nhs.stoppressure.co.uk/

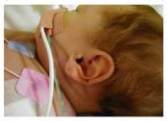
NHS England and NHS Improvement

Pressure ulcer categorisation

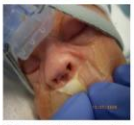
Device-related pressure ulcers (DRPU)

'Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes.'

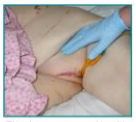
While some DRPU may also be allocated a category of damage, others may not as they are on parts of the anatomy that do not have the same structures as the skin – for example, the mucosal membrane. Where possible, a device-related ulcer should be categorised and the presence of a device noted by the addition of a (d) after the category.



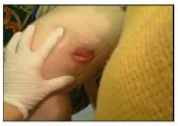
This infant has Category 1 damage to the cheeks and a small unstageable ulcer on the ear



This neonate has damage to the nares that cannot be categorised

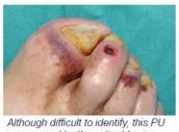


The damage caused by this urinary catheter could be categorised as a DTI (d)



Although difficult to identify, this PU was caused by the leather ring at the top of an old-fashioned calliper

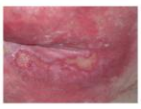
Damage has occurred where the spectacles and elastic from the oxygen mask press on the pinna of the ear



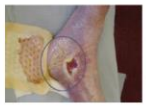
Although difficult to identify, this PU was caused by the patient having their feet caught in the bed sheets which were tightly twisted across the toes

Moisture-associated skin damage

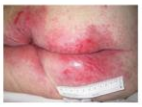
This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat



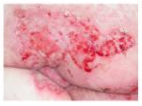
These multiple superficial lesions with diverse edges are typical of Incontinence Associated Dermatitis



The white cobblestone appearance of the tissue around this wound show evidence of significant maceration due to wound exudate remaining on the skin

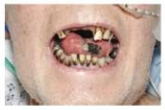


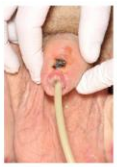
Wounds related to IAD such as these are often extremely painful



This wound demonstrates how the epidermis can easily be stripped away by incontinence

Mucosal pressure ulcers





Mucosal pressure ulcers can not be categorised as the tissue does not have the same layers as the skin and therefore does not conform to the definitions. These PU are therefore uncategorisable (NOT unstageable) . They are usually caused by devices and therefore should be recorded as PU (d), locally you may wish to denote them as "Mucosal" or "Uncategorisable".

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To cite this poster please use: NHS Improvement Pressure ulcer categorisation group (2019) Pressure Ulcer Categorisation. Available from http://nhs.stopthepressure.co.uk/

Publishing approvals reference 001103

Appendix 3 SSKIN Bundle

Please complete or affix addressograph Surname Forename Address Date of birth URN No. **SHEET NO.**	States of Jersey Ward / Area: Date / Time: Transfer Ward : Transfer Date: Name / Designation : Signature :

Pressure Ulcer Prevention SSKIN Care Plan

SSKIN Care Plan to be commenced for all patients	Please tick
~ at risk of pressure damage (Waterlow >10) or as a result of an informal assessment	☐
~ with existing pressure damage	☐
~ who have had pressure damage previously	☐

Problem:	The patient is at risk of pressure damage as a result of risk assessment, has existing pressure damage and/or has had previous skin pressure damage

Goal:	To minimise the risk of pressure damage and/or prevent further deterioration of existing pressure damage

SSKIN	INTERVENTIONS	Date	Signature
S **Surface**	An appropriate support surface has been selected based on assessment of patient risk.		
	Individual is bedbound/ wheel chair bound		
	Mattress type		
	Cushion type		
S **Skin**	Regular skin inspection is undertaken and documented		
	Vulnerable areas have been identified as:		
	A referral to the Tissue Viability Nurse has been made		
	A Wound Chart has been implemented a a result of identified pressure damage		
K **Keep Moving**	A Repositioning Chart has been commenced		
	A turning schedule is identified and reviewed		
	Mobility will be encouraged as patient condition allows		
	A referral to the Physiotherapist has been made		
	A referral to an Occupational therapist has been made		
	A Manual Handling assessment has been completed		
I **Incontinence**	A Catheter Care Bundle is needed and commenced		
	Toileting assistance is needed and is regularly offered		
	Incontinence pads are indicated		
	Skin cleansing regime(including barrier) identifed as:		
	A referral to the continence service has been made		
N **Nutrition**	A nutritional assessment has been completed		
	A referral to the Dietician has been made		
	The dietary regime has been identifed as		
	Nutritional intake is monitored (dietary intake chart)		
	Fluid intake is monitored (fluid balance chart)		

Additional Referrals	**Date**	**Signature**
Speech And Language Therapist (SALT)		
Other (Specify) -		
Other (Specify) -		

All practitioners will have a responsibility to implement, evaluate and review the SSKIN care plan.
Any interventions not dated and signed will be noted as not applicable to the patient.

© Initials of staff member Review date - Evidence Base WPD????

Pressure Ulcer Prevention

aSSSKINg Tool

Name:

URN:

aSSSKINg tool: to be completed for all patients with**:** - with any category of PU or previous pressure ulcers - with no pressure ulcer but at risk (as per pressure ulcer risk assess)		
Affix tit La		
a assessment	Complete risk assessment and holistic assessment to determine level of risk and to guide plan of care, referrals, equipment and interventions recommended/required.	**Completed (date):** Documented level of risk: Yes/No Care Plan: Yes/No Referrals to: Record in EMIS: Yes/No
S Safeguarding	**Do you need to consider raising a Safeguarding alert?** Do you have any concerns, are you keeping the patient safe? (consider capacity, risk assessment, MDT, safeguarding policy, safeguarding trigger tool) If **Yes** discuss with team leader and Safeguarding lead	Yes No
S Surface	**Select an appropriate support surface based on patients level of risk:**	
	Mattress Type (state):	
	Cushion type (state):	
	Heel Protector (state):	
	Other (*state*):	
	Ensure equipment is in good working order and on correct settings	Yes or No
	Is patient comfortable?	Yes or No
	Individual is bedbound/wheelchair bound?	Yes or No
	Does the person sleep in their chair?	Yes or No
S Skin	**Perform "Skin tolerance test" regularly and identify any evidence of pressure damage to:**	Determine frequency of checks:
	Buttocks	
	Elbow	
	Sacrum	
	Trochanter (hips)	
	Spine	
	Heels	
	Occiput	
	Toes	

	Other	
	A wound chart has been implemented if pressure damage has been identified	Yes or No
	Refer to Tissue Viability Specialist if Pressure Ulcer Categories 3 or 4 or multiple Pressure Ulcer Category 2	Yes or No
	Patient declined skin inspection (circle correct answer)	Yes or No
K Keep Moving	**Record current level of movement to identify problems with reduced mobility and ability to reposition**	
	Current level of movement (circle): Independent Restricted Relies on others or hoisted	
	Is current level of movement/positioning effective	Yes or No
	Is the person able to transfer independently	Yes or No
	Transfer aids or equipment required If yes, please detail:	Yes or No
	Is client able to reposition independently If no, advise repositioning schedule based on level of risk and skin tolerance to marking Complete “Moving & Handling risk assessment” if required	Yes or No completed
I Incontinence	Is the patient incontinent of urine If urinary incontinent, complete continence assessment Are incontinence pads indicated	Yes or No Yes or No
	Is the patient incontinent of faeces If yes, consider toilet regime	Yes or No
	Is the clients skin moist If yes, consider barrier cream – name product recommended:	Yes or No
N Nutrition	**Complete an “Adult Nutritional Screening Tool”**	
	Is the client eating and drinking adequately	Yes or No
	Has a referral been made to the Dietician if required	Yes or No
	Does nutritional intake require monitoring	Yes or No
	Does fluid intake require monitoring	Yes or No
g give information and share learning	Give patient/carer FNHC “Preventing Pressure Ulcers” information leaflet	Yes
	Use a collaborative multidisciplinary approach, get help and advice early (detail what action taken and who involved)	
	Keep clear documentation (detail of where recorded)	

Repositioning chart

Please Complete or Affix Addressograph

Surname:

Forename:

Date of Birth:

URN No:

Sheet No:

States of Jersey

Ward / Area:

Sheet No:

Name / Designation

Signature

Repositioning Chart for all those identified at risk of pressure damage, with existing pressure damage or recently had pressure damage

* Encourage all those identified as being **at risk** of pressure damage to change their position frequently and at least six hourly.
* Encourage all those identified as being **at high risk** of pressure damage to change their position frequently and at least four hourly.
* Individual tissue tolerance time should be taken into consideration when determining repositioning schedules. The above are available as a guide only.

Inspect the patients skin regularly. Patients on pressure redistribution equipment still require skin inspection and regular repositioning

Date	Time	Repositioning (using legend) From	To	Skin Inspection Comments	Identified repositioning schedule (hrs)	Other comments- include Pain e.g. Mouth care, eye care, traction obs etc	Signature / Designation

Legend - Left (L), Right (R), Back (B), Prone (P), Sitting Up (SU), Chair (C), Mobilising (M)

Appendix 4: Notification of injury

Jersey Care Commission

Notification of Incidents Form
Regulation 21: Notification of incidents, accidents and other events.
Please complete the form below and email to: notifications@carecommission.je
within 2 working days of the incident.

Information about the Registered Care Service			
Registered Provider: (Name and Address)	Registered Manager: (Name and Address)	Location of incident: (Address)	
Information about the person(s) affected by the incident			
Name:	Address:	Telephone: Email:	
Care receiver ☐	Care/support worker ☐	Volunteer ☐	Other (please state) ☐
Information about the incident			
Date of incident:	Time of incident:	Location of incident:	
Description of the incident:			
Were there any witnesses to the incident? If yes provide names and contact details:			
Was the person injured? If so describe the injury:			
Was medical treatment provided? Please state where and who by:			
Has any action been taken following incident: (if an investigation is taking place, please state so and send report when complete)			
Name and role of person submitting notification:			
Signature:	Date completed:		

Jersey Care Commission Standards for Home Care 2019 71

Appendix 5: Root cause analysis templates

Mini RCA – Pressure ulcers			
Patient's name		Age	
Datix no			
Completed by:		Date of completion	
URN		DOB	
Ward			

Assessment and findings							
1.	Date pressure ulcer detected/date deterioration of ulcer detected						
2.	Where was the person resident when the pressure ulcer was acquired						
3.	Current waterlow score	Score		Date			
4.	Previous waterlow score	Score		Date			
5.	Location and size of pressure ulcer(s)						
6.	Grade / stage of pressure ulcer(s)						
7.	Reason for admission / transfer?						
8.	Outline any **relevant** past medical history						
9.	Has a movement and handling assessment been carried out? (delete as appropriate)					Yes	No
10.	Were there delays in:						
	• using appropriate preventative equipment					Yes	No
	• providing nursing care					Yes	No
	If yes – please state reason						
11.	Comments / additional information:						
12.	Has there been a rapid onset / deterioration of skin integrity? (delete as appropriate)					Yes	No
13.	Has there been a change in medical condition? (delete as appropriate)					Yes	No
	If yes, explain briefly:						
14.	Were reasonable steps taken to prevent skin damage?					Yes	No
	Appropriate pressure relieving mattress (delete as appropriate)					Yes	No
	Regular turning (delete as appropriate)					Yes	No
	Heel protectors (delete as appropriate)					Yes	No
	Pressure relieving cushion (delete as appropriate)					Yes	No
	Regular skin checks (delete as appropriate)					Yes	No
	Other (please specify)						
15.	Were the pressure areas and any skin breaks monitored regularly					Yes	No
16.	Were treatments and care plans altered as necessary and recorded					Yes	No
17.	Was there concordance with the care plan?					Yes	No
18.	If no – please explain what the issues were:						
19.	Did the patient have capacity to make informed decisions?					Yes	No
	Was the capacity assessment recorded					Yes	No
	Are / were there concerns regarding family / carers?					Yes	No
	Is a safeguarding referral needed?					Yes	No
20.	Were agreed protocols followed? (delete as appropriate)					Yes	No
21.	**Summary of findings**						
22.	**Root causes –** what caused the pressure ulcer to develop / deteriorate?						
23.	Is there any concern about nursing care? (delete as appropriate)					Yes	No
	If yes please provide detail						

1

24.	What are the **lessons learned** (if any)?				
25.	**Actions** to be taken to address any lessons learned		By when	action plan	To be added (Y/N)
	•				
	•				
	•				
	•				
26.	If any actions are **not** being added to the action plan please specify monitoring arrangements				
27.	Being open (duty of candour) for **PUs grade 3 / 4** please detail discussion/s with the patient (family / carers if the patient consents / does not have capacity) about the pressure ulcers				
				Date:	
28.	Copy of the mini RCA provided to the patient / family / carers			Date	
Name		Designation		Date:	
Name		Designation		Date:	

Formal approval by pressure ulcer assurance group	
Signed _____ **Tissue viability lead**	**Date**
Signed _____ **Safeguarding lead**	**Date**
Signed _____ **Patient safety lead**	**Date**
Comments / actions (if any)	

Appendix 6

Pressure Ulcers: When to raise a Safeguarding Concern

This flow chart is to be used for inpatient services (HCS) and all community providers

An individual who develops Pressure ulceration is considered at risk and therefore consideration must be given to the safeguarding process. This process is inclusive of all ages: children through to adult. All agencies must be aware of indicators in determining when safeguarding issues may arise.

An individual develops pressure ulcer(s)

Pressure ulcer(s) verified as Category 1 or 2 by registered professional: complete Datix, Assure or appropriate incident reporting mechanism

Ensure reasonable steps are taken to prevent / manage pressure ulceration. Follow up so that these measures are seen to be effective. Seek advice from Tissue Viability Nurse if additional support/advice is required

Key points for all situations:

- Involve individual in decisions where possible.
- Take action and put preventative management measures in place.
- Ensure that the person, family and all carers communicate effectively
- Call a Multi-Disciplinary team meeting
- Refer to Tissue Viability Specialist Nurses where appropriate
- Ensure that follow up is robust and that if there is further deterioration consideration must be given to raising a Safeguarding Alert
- Organisational investigations to be carried out
- Consider level of harm and reporting to relevant organisations
- Identify lessons to be learned: consider Practice Learning Events for staff and carers

Link for Adult Safeguarding Referral: https://soj/depts/HSS/Documents/Read%20only%20forms/F%20Adult%20Safeguarding%20Alert%20Form.doc

Pressure ulcer(s) verified as multiple category 2, Category 3, 4, unstageable, deep tissue injury by Tissue viability nurse or trained professional: complete Datix, Assure or appropriate incident reporting mechanism

Health and Community Services

All Community including: FNHC, Hospice, GP, Care Homes & agencies, Children's services, charities

Complete Root Cause Analysis

Complete Root Cause Analysis

Complete Adult Safeguarding Decision Guide. Record conclusion in incident reporting and records. If threshold for adult safeguarding alert is met (Score of 15 or more) or clinical judgement concern, refer to Safeguarding following Safeguarding Adult's procedure.

Complete Adult Safeguarding Decision Guide. Record conclusion in incident reporting and records. If threshold for adult safeguarding alert is met (Score of 15 or more) or clinical judgement concern, refer to Safeguarding following Safeguarding Adult's procedure.

Decision by Safeguarding team as to whether a Safeguarding concern is to be pursued in conjunction with the Health Safeguarding team or the Tissue Viability Nurse Specialists.

	ADULT DECISION GUIDE-Safeguarding			
	Risk Category	Level of Concern		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	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 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/ 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			
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	

If the score is 15 or over, discuss with the HCS (safeguarding) as determined by local procedures and reflecting the urgency of the situation. Please send this decision guide along with the referral through to Adult Safeguarding team. 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 Datix record. The individual should be made aware they are being referred unless there is an identified reason not to share this with them such as lack of mental capacity in this area.

Appendix 8: Making Safeguarding Personal

"*Safeguarding may be everyone's business but making safeguarding personal means it is my business*"

Our multi-agency safeguarding policy and procedures provide a firm foundation for Making Safeguarding Personal in Jersey.

Making Safeguarding Personal (MSP) is a philosophical approach to promote responses to safeguarding situations in a way that enhances a person's involvement, choice and control as well as improving quality of life, alongside their well-being and safety.

The key focus is on developing a real understanding of what people wish to achieve. This includes agreeing, negotiating and recording their desired outcomes, working out with them (and their representatives or advocates if they lack capacity) how best those outcomes might be reached, and the extent to which desired outcomes have been realised at the end of the intervention

The full participation of people in all decisions affecting their lives should be encouraged.

In the past, people involved in adult safeguarding related incidents have said they can sometimes feel they have little control in respect of what is happening to them; are not involved in discussions; are rushed to make decisions or have little say over outcomes. 'Making Safeguarding Personal' therefore promotes a shift in culture and practice, which ensures that any intervention is more effective from the perspective of the person involved in the matter.

Whilst pressure ulceration may indeed be a matter for clinicians the principles of making safeguarding personal must remain at the forefront of our thinking. It is an expectation that the fullest involvement of the person will be explored.

Fundamentally, effective safeguarding is about people and organisations working together to prevent and reduce both the risk and experience of abuse or neglect. Safeguarding means protecting the health, wellbeing and human rights of people at risk, enabling them to live safely, free from abuse and neglect. Safeguarding also means making sure that the adult's wellbeing is supported and their views, wishes, feelings and beliefs are respected when agreeing on any action. In Jersey we endorse the ethos of **making no decision about me, without me**. Effective safeguarding is keeping people in control and aware of their rights.

In Jersey, we pride ourselves on the strength of partnership arrangements we have in place, and we recognise the skills, strengths and knowledge of all our partners in delivering quality safeguarding interventions to our citizens. Safeguarding is more effective when we work together cooperatively.

Remember: patients, community based clients, their carers, and their representatives are partners too.

1. Concerns raised with the Safeguarding Adults Team about Pressure Care

In respect of concerns relating pressure care – the Safeguarding Adults Team (SAT) will become involved where **neglect** is indicated.

Neglect can be caused through omissions of care or treatment – or less in less likely circumstances through deliberate acts of failures to care appropriately. For pressure related matters, that are not adjudged to be caused through neglect, the SAT **do not** have a role.

In light of our new multi-agency policy driver around **making safeguarding personal** – the SAT expect that a discussion with the patient (or their representative if they lack capacity) will have been held prior to a concern being submitted.

Health and Community Services (SAT) will:

- Ensure that any Safeguarding Adults concern is acted on in line with the Safeguarding Adults Procedures;
- Coordinate the actions that relevant organisations take in accordance with their own duties and responsibilities;
- Ensure a continued focus on the adult at risk and consideration of other adults or children;
- Ensure that key decisions are made to an agreed timescale;
- Ensure that any Safeguarding Plans (when required) are put in place with adequate arrangements for review and monitoring;
- Ensure that any actions and interventions are proportionate to the level of risk and enable the adult at risk to be in control, unless there are clear recorded reasons why this should not be the case;
- The Safeguarding Adults Team will make enquiries, or request partner agencies to do so, if they reasonably suspect a person who meets the criteria is, or is at risk of, being abused or neglected.

It is highly likely that partner agencies with the relevant clinical skills and knowledge will be called upon to carry out enquiries into pressure care related matters.

The SAT Safeguarding Coordinator is the Officer who has overall responsibility for ensuring there is an appropriate response to the concerns raised.

The Safeguarding Coordinator must ensure arrangements are made for the continued involvement of the person (patient) in all decisions made about them in accordance with their wishes and desired outcomes.

In relation to care settings, the consideration of risks to other people/patients' needs to be duly considered and factored. In such circumstances where there is believed to be a culture of neglect or poor care, then discussions with the individual need to be mindful of the likelihood, that any enquiries made are likely to go beyond their individually expressed outcome.