Pressure ulcer prevention in prisons: is enough being done?

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According to data published by the Ministry of Justice in the UK the total number of prisoners in England and Wales (as of July 2020) was just under 83,000, of those 13,764 were 50+ (Statista, 2021). The charity Age UK discussed that the 50+ age group is the fastest growing population in prisons and in recognition of this undertook a review of health and social care to determine if it was currently meeting the needs of individuals (Age UK, 2019). Their recommendations highlighted a number of areas including; recognising the diversity of the older individuals and the provision of the same basic health and social care as non-prisoners.

Guidelines for the prevention of pressure ulcers (PU) developed by the NHS Midlands and East (2012) included prisons as a setting where screening for PUs should be undertaken. The current National Institute for Health and Care Excellence (NICE) Quality Standard (QS89) for PUs applies to all settings (NICE 2015). Although prisons are not mentioned specifically, there would be an expectation that the standards would apply to this environment. A search of the existing literature identified one article that focussed on the provision of tissue viability services across 12 offender institutions representing different categories of prisons (Bussey, 2016). Regarding the provision of equipment within prisons, Bussey (2016) discussed that under The Care Act (HM Government, 2014) the local authority should provide equipment required for social care whereas the National Partnership Agreement requires that NHS England provides equipment for healthcare (National Offender Management Service, Public Health England and NHS England, 2013) that can present challenges accessing appropriate equipment.
Samantha Holloway

1. Do we know enough about the prevalence of PUs in UK prisons? How might this be addressed?

KS: The prevalence of PUs in prisons appears under researched. From visiting several prisons across the UK, each establishment significantly varies, for example in their environment — contributing environmental factors can impact the development of PUs. Many prisons are old and listed buildings and were not built with older prisoners or those with complex needs in mind. This would lead us to believe that the prevalence of PUs will differ from prison to prison. What we do know however, is that the general ageing population is increasing and the prison community is no exception, projected to significantly rise further (Sturge, 2019). Age is a risk factor in the development of PUs (Moore et al, 2011) so we are therefore more likely to see an increase in this as the ageing population continues to increase.

AKF: We certainly don't know enough as the data isn't being collated as far as I know. It won't be easy to address due to the transient nature of some sentences, transferring between prisons, potentially large populations and assessment concordance. Security issues may also present a barrier, for example a time and date could be set for data collection but an internal security alert at one prison could prevent their participation at the last minute: alerts are quite frequent and can lead to the whole prison going through 'lockdown' for a period of time. Prevalence data or potentially incident data, would be easier to collect in those prisons dedicated to those with a "life" sentence. This is due to reduced population movement (not used for remand). With this in mind, and the fact that "lifers", by the nature of their sentence, are ageing, the opportunity is greater to collect PU data in these prisons. Such data could be skewed however if the prisoner does not present to a health professional with their wound and the PUxs is not recorded. This can also occur in community settings, the difference being that if they're on a caseload they should have been assessed whereas in prison unless they seek healthcare there will be no one assessing them for PUs in line with Best Practice.

2. Are there barriers to implementing Clinical Practice Guidelines and Best Practice Recommendations for the prevention of PUs in prison settings?

KS: Implementing best practice for

pressure care in the prison environment has its challenges. Imprisonment should be perceived as a sentence to deprivation of freedom and not to poor health inequalities. If we would like to remain prudent in our practice then prevention is key in pressure care. A simple solution such as a suitable chair with arms, can support someone to stand who is less physically capable. However, there is often lack of understanding from staff and other prisoners who consider this as a "luxury" rather than being essential to good pressure relief. Where prevention has failed, pressure care management can become challenging. Should a pressure cushion or appropriate mattress be required, difficulties arise when they do not accurately fit to the chair or bed, which may mean that a hospital bed is required and of course incurs more costs. As an Occupational Therapist, interventions also become limited due to the challenges of the environment, again where equipment to increase mobility and transfers may not be suitable for the prison environments fixtures. There are often challenges with responsibility in equipment provision as Samantha discussed, this tends to reside with either health or social care depending on needs. Where there is a need for a permanent fixture, then this tends to become the responsibility of the prison.

AKF: Many UK prisons are significantly aged buildings with poor facilities and small rooms not conducive to effective PU prevention i.e. where a standard prison issue bed is 6ft, prisoners taller than that would be unable to lie down fully and offload their heels effectively, should that be required. Equipment can be a large factor in PU prevention and treatment, the use and accessibility of profiling beds and specialist mattresses is taken for granted in the wider population, yet for prison populations this is a huge challenge partly because of cell size but also the ligature risk from wires. The loss of hospital wings that had an inpatient population where such equipment could be used as standard is not necessarily a good thing from a preventative/treatment perspective. In addition, many older patients with functional limitations/poor pain control who need a prompt or assistance to reposition will not be able to access such support at the desired frequency and consistency due to prison regimes, security and small number of health care staff. Where risk management is concerned, as with any patient, the higher risk has to take priority, for the prison population that risk has to be balanced further with the prison regimen and their sentence: within this environment health is secondary to the custodial sentence. One of the greatest barriers however is staffing, not only of health professionals but also prison officers available to escort offenders when required. Agency staff are relied on to deliver health care and may not have the knowledge base required for effective pressure ulcer prevention in this population.

3. What particular challenges have prison settings faced in terms of pressure ulcer prevention during the Coronavirus pandemic? How might these be overcome?

KS: Lockdown has meant that prisoners experienced up to 23 hours per day in their cell (often double occupancy). As expected, this has resulted in deconditioning due to increased in-activity with long periods of sitting and bedrest causing a functional decline and an increased risk of pressure ulcers. For older prisoners, this can provoke a downwards spiral of increasing frailty and again increasing the risk to pressure ulcers (Goswami 2017). Some prisons provided prisoners with in-cell exercises and information leaflets on how to maintain good pressure relief during this difficult period. Prisoners had very little time to carry out their 'domestic tasks' and regular activities of living so were therefore very unlikely to prioritise visits to healthcare during this time. As a result, we discovered one individual with a grade III pressure ulcer after failing to report his initial concerns due to the time limitations out of cell and was then too worried about the repercussions following the extension of its deterioration..

4. Are there strategies/approaches that can be used to facilitate offender engagement with self-care to maintain healthy skin to reduce the risk of pressure damage?

KS: Occupational Therapists play a significant role in the multidisciplinary team to support prisoners in maintaining their pressure care. Advice can be given on appropriate seating in the prison environment to reducing PUs and individuals can be advised on how to safely adjust their posture. Posture adjustment and weight shifting can be incorporated into everyday routines which makes this less obvious to others for those who are particularly vulnerable. Where an individual's mobility is reduced, Occupational Therapists can provide an assessment of transfers, as often a common factor in the development of PUs is friction and shearing during this process. Bed sheets and rough surfaces are a prime example of this. Prisoners should also ensure that they maintain a nutritional diet by selecting healthy choices on the menu and keep as active as possible by engaging in activities or simply walking outside in yard. Both prisoner and staff education in PU prevention and care is essential and both should be encouraged to report any concerns. However, is this enough? Prisons should ideally deliberate the long-term implications if they do not reconsider their environment and fixtures and develop insight as to what is perceived as a luxury, is in fact basic needs to maintaining good overall health and wellbeing of the prisoners.

AKF: Any engagement, be it with a prisoner

or service user, will only be effective if they have buy in. In prisons, healthcare, like many other aspects of prison life, is viewed as a bartering opportunity or opportunity to get something extra. Therefore, the clinician would always need to be aware of this when reviewing options. Should that barrier be hurdled education opportunities could be sought, through the relevant prison section. Prisoners identified as at risk during their reception and/or second health check could be flagged for a health education session.This is a good opportunity to use the Purpose-T tool. By having a structured environment with resources, a set group who can meaningfully consider their risk and what it means to them, as opposed to a generic group who would have the potential to sabotage such a session, strategies to manage their individual risk could be explored. Information retention is a challenge for many of us and a well-designed leaflet aimed specifically at this population is essential, it could be provided at the health check where their risk was identified so that before any follow-up education they have had an opportunity to update on the health professionals concerns and contribute to the education session. Where there are patients identified as immediate risk or with existing damage a Treat Eazy overlay could be considered for issue: these are used in community for patients who wish to stay in the marital bed but need pressure relief or have existing pressure damage.

CONCLUSION

This debate really highlights how sections of the population despite their incredible vulnerability are missed because of perceived inaccessibility issues. A parallel could be drawn with the homeless population and the challenges of delivering wound care to them, yet this has become a more widely studied population with multiple papers authored particular around leg ulcer management. However the prison population seems completely ignored, a quick PUBMED search revealed only 1 article that mentioned them (McDermott – Scales et al 2009). The challenges mentioned by the 2 debate respondents highlight the issues that make delivery of care to this particular population , I am certainly aware of clinical colleagues who see patients in prison struggling to find diary time as they know they need to block out a whole day for a visit in case anything happens whilst they are on site. But we can not let this be a reason to not deliver high quality care for people with any kind of wound and we would welcome comment from any clinician who has worked in these areas about how they have found solutions to these problems.

Jacqui Fletcher

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