

Pressure ulcers: are they are a safeguarding issue in care and nursing homes?

KEY WORDS

- ▶ Care homes
- ▶ Pressure ulcers
- ▶ Residential homes
- ▶ Safeguarding

The impact of the Care Act (Department of Health [DH], 2014) and adult legislation such as the Mental Capacity Act (Deprivation of Liberty Safeguards, 2009) has resulted in closer scrutiny of care provision and outcomes for those living in residential and nursing homes. Issues are being raised concerning safeguarding and the incidence of pressure ulcers, and whether the two are inextricably linked. A literature review was undertaken searching EMBASE, MEDLINE, PsycINFO, BNI and CINAHL, using the key words 'pressure ulcers', 'risk', 'nursing', 'care home' and 'safeguarding'. No date limits were set. Five papers were retrieved and screened; all five were included in the review. Papers were retrieved from the USA and Australia, with none retrieved from the UK. In general, the findings did not show that the incidence of pressure ulcers is considered to be a safeguarding issue. A number of variables impacted pressure ulcer development, such as: staffing levels; ratio of qualified to non-qualified staff; and lack of education in recognising and prevention of pressure ulcers. Residential homes with a high incidence of pressure ulcers delivered poor quality care. As this was a literature review, it would be beneficial to undertake a systematic review of the literature in the future.

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This paper presents the results of a literature review investigating the evidence and research relating to quality and reporting mechanisms available in care and nursing homes. The review focuses on reporting of pressure ulcers and whether pressure ulcer development is perceived to be a safeguarding issue. Safeguarding of vulnerable adults has been defined as helping people with care and support needs to live full lives, free from abuse and neglect (Social Care Institute for Excellence [SCIE], 2015). The SCIE continues to define a vulnerable adult as 'any person aged 18 years or over, who is, or may be, unable to take care of themselves, or who is unable to protect themselves against significant harm or exploitation.' This definition encompasses preventing abuse, minimising risk without taking control away from individuals, and responding proportionately if abuse or neglect has occurred (SCIE, 2015). Development of avoidable pressure ulcers could be perceived as an act of neglect or harm, and therefore a safeguarding issue.

Pressure ulcers are localised areas of soft-tissue

injury resulting from compression between a bony prominence and an external surface (Lyder, 2003). All age groups are at risk of compromised skin integrity if appropriate interventions are not implemented in a timely manner; however, older people who have a range of comorbidities, reduced mobility, poor cognition and poor nutrition can be at a higher risk. Indeed, Keelaghan et al (2008) reported that residents of long-term care facilities, including nursing and care homes, had higher prevalences of multiple risk factors for pressure ulcer development than community-dwelling persons. An audit undertaken across five NHS Trusts in England (Ousey et al, 2013) identified the prevalence of pressure ulcers (all categories) to be 18.1% in residents in acute and community healthcare settings. In the USA, one in nine long-term care residents have been reported as having developed a pressure ulcer (Park-Lee and Caffrey, 2004), with some homes reporting prevalences of category III and IV pressure ulcers of greater than 20% (Pieper, 2012).

Pressure ulcers represent a significant burden to healthcare environments and patients, both financially and in relation to reduced health-related quality of life outcomes globally. In the UK, estimates regarding the financial cost of treating a pressure ulcer range from £1,064 (category I) to £10,551 (category IV) (DH, 2010).

There has been some debate surrounding whether pressure ulcers are avoidable. Black et al (2011) presented the results of a consensus meeting, stating that unavoidable pressure ulcers may develop in patients who are haemodynamically unstable, terminally ill, have certain medical devices in place, and/or are non-adherent with artificial nutrition or repositioning. Although there was agreement that high-risk clinical situations could lead to unavoidable pressure ulcers, the consensus reported by Black et al (2011) was that prevention programmes should be provided, and no predetermination of pressure ulcer development should preclude prevention, regardless of setting.

There are stringent reporting mechanisms for the incidence of category II, III and IV pressure ulcers in the NHS, and for those perceived to be avoidable. However, less is known about reporting mechanisms in care and nursing homes, and whether staff in these institutions perceive pressure ulcer development to be a safeguarding issue.

METHODS

A literature review was undertaken, searching the EMBASE, MEDLINE, PsycINFO, BNI and CINAHL databases using the following key words: 'pressure ulcers', 'risk', 'nursing', 'care home' and 'safeguarding'. No date limits were set. The final number of articles included was five; one paper was from Australia (Madsen and Leonard, 1997) and four were from the USA (Berlowitz et al; 2000; Hickey et al, 2005; Baier et al, 2003; Cai et al, 2010). All papers reviewed were dated, with none being published since 2010.

Review of the papers indicated that there is currently little evidence or research investigating pressure ulcer development and the potential link to safeguarding.

QUALITY PROGRAMMES

A number of the reviewed studies discussed quality of care in nursing homes (Berlowitz et al, 2000; Madsen and Leonard, 1997). In a 5-year, US-

based study, Berlowitz et al (2000) identified that the quality of a nursing home can be measured against the prevalence and incidence of pressure ulcer development in that home. They highlighted that residents who developed pressure ulcers had a number of common characteristics, including previous history of pressure ulcers, comorbidities, incontinence, immobility and low body mass. They noted that pressure ulcers occurred in predominately older (82.4 +/-10.3 years), female residents (77%) with reduced mobility.

Data analysis identified that the implementation of guidelines and adoption of quality improvement practices (including all patients receiving a comprehensive holistic assessment) resulted in a decreased incidence of pressure ulcer development.

Baier et al (2003) explored quality improvement for pressure ulcer care in nursing homes by means of training and education workshops. The study commenced with 35 homes, of which two withdrew and a further four did not complete the programme. The paper concluded that there was an association between the qualified staff-to-resident ratio and the quality of care provided. Baier et al (2003) also compared government-run to privately owned facilities, finding that quality improvement for pressure ulcer prevention is needed and that interventions such as training and education workshops slow the rate of pressure ulcer development.

CLINICAL INDICATORS

An evaluation of pressure ulcer assessment using the Waterlow scale in a nursing home over a 2-day period (Madsen and Leonard, 1997) identified that the majority of residents were at risk of pressure ulceration and required various types of intervention to meet clinical needs, such as a comprehensive assessment and care planning. The authors found that only four of these residents experienced any breakdown in skin integrity, and that correct, regular use of the Waterlow scale assisted in early identification of residents at risk of pressure damage and prompted early intervention of preventative measures.

LOW STAFFING LEVELS

Low staffing levels may have an impact on pressure ulcer development. Hickey et al (2005) examined the association, via patient notes review, between staff turnover rates, skill mix,

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shift patterns and staffing levels and pressure ulcer development in 35 Department of Veterans’ Affairs nursing homes between 1998 and 1999. Data analysis demonstrated that although there was no strong linear association between staffing levels and pressure ulcer incidence, when 10 of the homes reduced their staffing levels or used temporary staff, a 2.1% increase in pressure ulcer development occurred. The authors concluded that a high staff turnover or inadequate staffing levels reduced patient outcomes.

REDUCING THE INCIDENCE OF PRESSURE DAMAGE

A range of interventions have been identified that may reduce incidence of pressure ulcers and improve quality of life. Madsen and Leonard (1997) highlighted that nurse education could have a positive effect on the incidence of pressure ulcers, combined with the use of a recognised pressure ulcer risk calculator in clinical areas. The effectiveness of an introduction of national guidelines was debated by Baier et al (2003), who showed that guidelines demonstrated a reduction in pressure ulcer incidence when actively promoted. Baier et al’s study introduced guidelines including: developing care plans to address specific risk factors (i.e. immobile residents, the importance of frequent repositioning, use of pressure redistributing equipment), and the application of a pressure ulcer risk assessment tool. The authors warned that the adoption of national and local standards was often slower than in the acute sector, with staff not always becoming aware of ulcers in a timely manner, and suggested that homes with a high incidence of pressure ulcers often had problems with other quality measures, such as record keeping. They concluded that reduction in the incidence of pressure ulcer development was associated with structured education around pressure ulcer development and treatments, one-to-one mentoring, auditing and regular feedback to staff.

However, Berlowitz et al (2003) warned that the introduction of national guidelines does not mean that all staff will adhere to these guidelines. In their study of the implementation of guidelines in nursing homes, they were unable to identify any evidence to support the hypothesis that nursing homes were adhering to the national guidelines. By contrast, a study of nursing homes (Saliba et al, 2003, cited by Baier et al, 2003) concluded that

evidence from other healthcare settings showed that a quality improvement approach can lead to improved care. It was highlighted that nursing home staff need to recognise the importance of reporting low staffing levels and increased numbers of patients who are at risk of pressure damage, in order to allow for managers to review resources and staffing levels.

DISCUSSION

The profile of adult safeguarding has increased following the implementation of the Mental Capacity Act (MCA) (2005), with its inclusion of Deprivation of Liberty Safeguards (DoLS) (DH, 2009a). Identifying avoidable harm in a timely manner, and implementation of preventative measures, have been highlighted as important and essential elements of care in nursing and care homes. Safeguards have been designed to protect vulnerable groups of people, including the elderly, in care and nursing home settings, with specific guidance for care homes (DH, 2009b). There is no single definition of deprivation of liberty, but the DH guidance provides a standard process that care homes should follow if they are concerned that deprivation of liberty may occur, while providing a care plan based on the residents’ best interests (DH, 2009b). The MCA DoLS (2009a) should be used for people in residential and care homes who lack the capacity to make decisions for themselves and where personal freedom needs to be restricted in their best interests.

Adult safeguarding has been identified as a priority for all healthcare providers; in particular, pressure damage and development of pressure ulcers has been highlighted in the publication of the Care Act (CA) (DH, 2014). Following the introduction of the CA, the definition of a vulnerable adult has been expanded to include: neglect and poor care practice within an institution or care setting such as a hospital, care home, or in relation to care provided in one’s own home. This may range from one-off incidents to ongoing ill treatment. The CA discusses the nature and timing of interventions, highlighting that nursing and care homes will be held responsible for neglectful care or practice that could result in pressure ulcer development.

Across the UK, health trusts are reporting and undertaking root cause analyses of all category III and IV pressure ulcers. Most NHS organisations use the National Patient Safety

Framework (NPSF) root cause analysis tool for carrying out investigations. If additional causative factors are identified, such as poor practice, acts of omission or delay of reporting, then an alert would be generated via local safeguarding procedures and policies published by local safeguarding adult boards (NPSF, 2015). Nursing and care homes should also adhere to this guidance, yet there is little research that explores how well safeguarding is understood or its relationship to pressure ulcer development.

SUMMARY

Although a lack of literature was identified in relation to reporting of pressure ulcer development as a safeguarding concern in care and nursing homes, safeguarding of vulnerable adults is becoming a key area of discussion for both commissioners and providers within the NHS, and nursing and care homes. This means that care and nursing home staff will need to develop their knowledge base and understanding in relation to safeguarding. Documentation will need to ensure that safeguarding is assessed and reported appropriately. As this was a literature review, it would be beneficial to undertake a systematic review of the literature in the future.

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