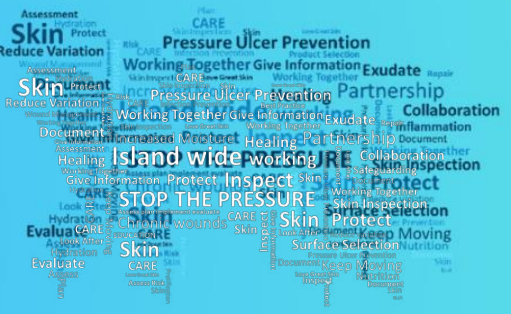
JERSEY

ISLAND WIDE

PRESSURE ULCER

PREVENTION AND MANAGEMENT

FRAMEWORK



APRIL 2025

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Ratification

Final ratification by Health & Care Jersey (HCJ) (HCJ Policy and Procedure Ratifying Group and Family Nursing & Home Care (FNHC) (Organisational Governance Approval Group).

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.

Health and Care Jersey

Family Nursing & Home Care

Contents

INTRODUCTION

This document updates and replaces the Island-Wide Pressure Ulcer and Prevention and Management Framework 2021. It has been updated to incorporate clinical standards on prevention and management of pressure ulcers adapted from Health Improvement Scotland Standards for Prevention and Management of Pressure Ulcers 2020.[2]

The Framework has been revised by a multi-professional group and is in place to provide a standardised Island-wide approach for the provision of care to ensure those who may be at risk of developing pressure ulcers and those with existing pressure ulcers are managed appropriately.

Each organisation and healthcare provider has the responsibility to ensure that specific policies and procedures are in place in relation to pressure ulcer prevention and management, including personal care and risk assessment tools, which reflect the principles of this Framework.

What the Framework is

- it is a resource to ensure the standardised care for pressure ulcer prevention and management

Why we need an Island-wide framework

- to guide best practice for prevention and management of pressure ulcers.
- to increase awareness of health care professionals and people receiving care

Who it applies to

- any person at risk of developing, or identified with, pressure ulcers regardless of age (including babies and children)
- services and organisations responsible for pressure ulcer care across health and social care

WHAT IS A PRESSURE ULCER?

"A pressure ulcer is 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). The damage can be present as intact skin or an open ulcer and may be painful."[1].

Anyone can get pressure ulcers (sometimes known as 'bed sores' or 'pressure sores')[2] but certain factors can make them more likely to develop, or for existing pressure ulcers, to deteriorate: [2-6,15,16,17,18,19].

Risk factors

- reduced levels of mobility or physical activity (for example, when people spend extended periods in bed due to illness or following surgery)
- medical conditions that reduce blood supply or make the skin more fragile (for example, diabetes, peripheral arterial disease, kidney failure, heart failure, multiple sclerosis and Parkinson's disease)
- incontinence or other causes of increased moisture on skin
- compromised nutrition and hydration
- cognitive impairment
- palliative and end of life care needs
- acute illness
- reliant on others for support or care needs to be met

A pressure ulcer can cause some major complications and ongoing health problems. These include pain, a wound that may smell unpleasant, embarrassment and loss of dignity, cost of increasing carer support, equipment, reduced quality of life, infection, sepsis and even death. People who develop pressure ulcers have a 4.5 times greater risk of death than persons with the same risk factors but without pressure ulceration.[8]

Pressure ulcer categorisation is defined by NHS Improvement (2019). NHS Pressure Ulcer Categorisation. See Appendix 2.

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 the first visit from a Community Nursing Service.

The prevention and management of pressure ulcers is an island-wide priority. People at risk of developing or who have pressure ulcers are cared for across all healthcare settings and services, including in their own homes. Whilst most pressure ulcers occur in older people, it is possible that anyone of any age can develop a pressure ulcer depending on their risk factors or their situation.

Locally and nationally, it is recognised that there is the need for a consistent, standardised approach to pressure ulcer prevention and management that is inclusive of all those impacted to:

- ensure that person with or at risk of developing a pressure ulcer receives the care they need at the right time
- improve detail surrounding escalation and clinical pathways to clarify individual and professional responsibilities and guide practice
- ensure health and social care professionals have relevant knowledge and skills, as well as effective and clear communication across all services
- reduce variation in practices by adopting an Island-wide approach
- offer guidance on the principles of Safeguarding and that any Safeguarding concerns relating to pressure ulcers are reported, (including care providers, clinicians, anyone undertaking safeguarding enquiries, unpaid carers, relatives and individuals themselves), as any tissue damage resulting from pressure should be considered a potential concern

Pressure ulcers, which are largely preventable, cause distress to individuals and their families. While the treatment and response to pressure ulcers is predominantly a clinical one, the prevention of them is a shared responsibility.

It is essential that any assessment, including risk assessments, address the likelihood of pressure ulcers developing and what action must be taken to prevent them.

This will be as true for an individual living at home as those living in a regulated care setting. It is also vital that carers, whether family, friends or paid carers, receive training in the prevention and signs of developing pressure ulcers, as well as how and when to escalate it to relevant health services. Those responsible for carrying out assessments and arranging services need to be alert to this issue and have easy access to clinical advice to support care planning.

WHO DOES THE FRAMEWORK APPLY TO?

This framework applies to:

- any person at risk of developing, or identified with, pressure ulcers regardless of age (including babies and children)
- services and organisations responsible for pressure ulcer care across health and social care

The standards within the framework are suitable for use for those with both physical and mental health care needs and seek to inform and support care delivered by all health and care professionals including:

- hospitals
- general practice
- community services
- hospices and independent clinics
- care homes
- home care providers
- day centres
- other care providers such as prison and ambulance services

HOW WILL THE FRAMEWORK SUPPORT IMPROVEMENTS IN THE PREVENTION AND MANAGEMENT OF PRESSURE ULCERS?

The framework proposes an evidence-informed island-wide, standardised pathway of care to prevent and manage pressure ulcers. The framework outlines what best practice[2] should look like and is based on recommendations in the following:

- National Institute for Clinical excellence (NICE) Guideline: Pressure Ulcers: prevention and management 5 and NICE Quality assurance standard: pressure ulcers [6]
- National Wound Care Strategy Programme 2024 [3]
- European Pressure Ulcer Advisory Panel (EPUAP) 2019,6 [7]
- Health Improvement Scotland: Prevention and Management of Pressure Ulcers Standards 2020 [2]
- Jersey Care Commission Home and Care Standards 2022 [20]
- Children's Standards | Jersey Care Commission [22]

This framework should be read alongside local legislation and policies and relevant national health and wellbeing outcomes and health and social care standards.

The framework supports the principles of realistic medicine[12], recognising the importance and value of informed choice and ensuring that people are at the centre of care decisions. In addition, the framework emphasises the role of multidisciplinary working, coordinated care and support for people with, or at risk of developing, pressure ulcers.

By adopting the core principles of the Scottish Standards[2], it provides a solid process for implementing and improving the care and preventative approach to the issue of pressure ulcers at both organisational and individual level.

The standards are set out in a way that allows for people receiving care to understand how the standards apply to them and supports staff, organisations and healthcare providers and health care professionals (HCPs) delivering care to understand their roles and responsibilities, with examples of how this is to be achieved.

All standards follow the same format which includes:

- a clear statement of the standard
- a rationale providing reasons why the standard is considered important
- a list of criteria describing the required structures, processes and outcomes

For people receiving care	Information and support are available for anyone at risk of developing, or identified with, a pressure ulcer
For staff	The principles of the framework recognise the need for: • open, joint communications across all areas of care • person-centred implementation of appropriate interventions, to help reduce the incidence of, or deterioration in existing, pressure ulcers • the escalation of any concerns Health professionals are responsible for seeking organisational. support for the principles of this framework and the implementation of the recommendations.
For organisations, healthcare providers	Each organisation/care provider has a responsibility to demonstrate. leadership and commitment to the prevention and management of pressure ulcers. 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 • 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

MONITORING COMPLIANCE AND EFFECTIVENESS OF THE FRAMEWORK

Monitoring and improving performance against these standards, at both organisational and individual level will support any additional improvements needed to support care provision and raise awareness.

- each organisation/care provider will have audit in place for monitoring compliance with the Standards within this framework

- any area of concern identified, will result in the requirement for an improvement plan to be implemented and evaluated at the next audit

Pressure ulcer prevention is everyone's business. By working together and knowing when to ask for additional support, risk of harm will be reduced.

STANDARDS

Adapted from: Health Improvement Scotland

Healthcare Improvement Scotland

Prevention and management of pressure ulcers standards

Standard 1: Leadership and governance.
Organisations demonstrate leadership in the prevention and management of pressure ulcers.

Standard 2: Staff education and training.
Organisations demonstrate 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-centred information and support.
Information and support are 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-centred care plan is developed and implemented to reduce the risk of developing pressure ulcers.

Standard 7: Assessment, grading and care planning of identified pressure ulcers.
People with identified pressure ulcers will receive a holistic assessment and experience high quality and person-centred treatment and support.

Standard Statement

The organisation/care provider demonstrates leadership in the prevention and management of pressure ulcers.

(Aligns to Jersey Care Commission Standards for Care Homes 12 and home care 9, Children and Family Community Nursing 1 & 2, Children's Home services 2,4)

Rationale

A strategic and co-ordinated organisational approach can improve health and wellbeing outcomes. Effective governance arrangements, including accountability, adverse events management, escalation procedures and data monitoring, are critical for the delivery and assurance of prevention and management of pressure ulcers.

These arrangements should adhere to the organisation's statutory duty of candour responsibilities, ensuring openness, honesty, and support in the event of unintended or unexpected incidents that cause harm or death.

Implementation of standards and guidance supported by training and improvement programmes, enables the effective prevention and management of pressure ulcers.

Criteria	
For the prevention and management of pressure ulcers, the organisation can demonstrate:	• implementation of national and local policies, procedures, guidance and standard • ongoing quality improvement • adherence to duty of candour regulations and responsibilities • adherence to local reporting guidance • a multidisciplinary approach • collection, monitoring and review of data with action plans as required • an education and training programme

There are locally agreed pathways and procedures for the prevention and management of pressure ulcers, which support timely, effective and person-centred communication, documentation and transfer of information to ensure continuity of care between teams and settings.	• include response times • facilitate cross-organisational support • appropriate referral processes and access to specialist advice and equipment when indicated • detail escalation levels and reporting processes if access to specialist advice and equipment is not available when required

What does the standard mean for people receiving care?

People:

- are supported by staff who are committed to the prevention and management of pressure ulcers
- can be confident that the organisation will always communicate clearly and openly with them (and their representatives, where appropriate)

What does the standard mean for staff?

Staff will:

- understand, and are fully engage in, the organisation's approach to pressure ulcer prevention and management
- be responsible for identifying and escalating issues relating to pressure ulcer prevention and management, including how and when to refer for specialist advice or support, for example, tissue viability nurse, podiatrist or safeguarding leads

What does the standard mean for the organisation/care providers?

Organisations:

- demonstrate their commitment to pressure ulcer prevention and management through robust governance structures
- ensure that effective and efficient pathways for specialist advice and treatment are developed and implemented, with clear timeframes for responses noted
- monitor data and undertake learning to support improvement in care planning, delivery and sharing of information, particularly across care settings
- comply with duty of candour regulations and responsibilities where appropriate
- ensure that information is responsive to everyone's needs and is regularly reviewed to ensure it remains up to date

Practical examples of evidence of achievement

- pressure ulcer prevention and management local policies, protocols, pathways and tools, for example aSSKINg care bundle, Purpose T risk assessment
- improvement work, including action plans, data collection and review of data
- training data including cross-organisational working and evaluation reports
- use of improvement data, audit reports and adverse event reports to support learning and improvement
- referral pathways to local teams/services including nursing, AHPs and social care professionals
- protocols, standard operating procedures (SOP) or guidance for where to access equipment and funding options, for example dressings, bariatric or paediatric equipment, seating and pressure redistributing equipment
- completed care plans and transfer documents demonstrating multidisciplinary working/meetings and documentation, particularly during care transitions or discharge feedback from the person receiving care (and/or their representative) using survey methods
- duty of candour monitoring including organisational openness, honesty and supportiveness after instances of harm or death
- incident reporting and review of Root Cause Analysis to determine learning at organisational, team and individual levels

Useful documents & suggested resources for this Standard

Jersey Care Commission for reporting information and Adult and Children's Standards
SPOR: Mon to Fri - office hours 01534 444440 | spor@health.gov.je
Escalation pathway when concerns raised
Generic reporting pathway when pressure ulcer present
Purpose T risk assessment
National Wound Care Strategy Programme: pressure ulcer categorisation
National Wound Care Strategy Programme: Education & Recommendations
Adult Safeguarding Decision Tool
Wounds-UK Journal & Best Practice Documents

Standard Statement

The organisation/care provider demonstrates commitment to the education and training of all staff involved in the prevention and management of pressure ulcers,

(Aligns to JCC standards for Care Homes 6 and Home Care 3 & 6, Children and Family Community Standards 3 & 8, Children's Home Services 3 & 13).

Rationale

Staff should be appropriately educated and trained in the prevention and management of pressure ulcers. A multifaceted, evidence-based approach to pressure ulcer care is essential to improve health and wellbeing outcomes. This approach should be underpinned by a professional development framework to support staff competency in the prevention and management of pressure ulcers.

Criteria	
The organisation/care provider implements a comprehensive and multifaceted education and training programme that includes:	• an assessment of staff training needs that is responsive to staff roles, responsibilities and workplace setting • validated online tools where applicable or in person training sessions • training and continuing professional development plans, including updates for pressure ulcer prevention and management • guidelines, policies, assessment tools and care planning • application of quality improvement methodology for pressure ulcer prevention and management, including service developments • evaluation of the provision, quality and uptake of training
The organisation/care provider is committed to delivering education and training programmes for pressure ulcer prevention and management, appropriate to roles and workplace setting, which include:	• initial assessment and reassessment of risk, including contributing factors, such as frailty, limited mobility and underlying health condition • person-centred care planning for prevention of pressure ulcers, including management of risk • assessment, categorising and person-centred care planning • prevention and management of wounds and systemic infection • the importance of a multidisciplinary approach, such as access to specialist advice, treatment and equipment recommendations • the education and training needs of specialist practitioners, for example tissue viability nurses and podiatrists, are aligned to professional development frameworks
All staff have access to clear guidance on:	• their roles and responsibilities in relation to pressure ulcer prevention and management • identifying and addressing their own continuing professional development, education and training needs

What does the standard mean for the organisation/care providers?

Organisations:

- ensure a quality improvement approach and promote a learning culture to support effective prevention and management of pressure ulcers
- equip staff with the necessary knowledge and skills, appropriate to their roles and workplace setting, in the prevention and management of pressure ulcers
- ensure staff are supported to access and attend multifaceted training and education appropriate to their role

What does the standard mean for people receiving care?

People:

- can be confident that their health or social care professional is appropriately trained and competent in their role in preventing and managing pressure ulcers
- will receive care and support that is informed by evidence and best practice

What does the standard mean for staff?

Staff will:

- demonstrate knowledge, skills and competence relevant to their role in the delivery of care to people with, or at risk of developing, pressure ulcers. This includes identification and referral of people requiring specialist services
- promote best practice, consistency and continuity of care in the prevention and management of pressure ulcers, appropriate to their role
- are supported to access and attend multifaceted training and education appropriate to their roles

Practical examples of evidence of achievement

- expectations for training standards for multiple health professionals are outlined in the document: Wound-Care-Workforce-Framework-FINAL-for-publication.pdf (skillsforhealth.org.uk)
- training to be in line with the standards in the core curriculum and relevant to the role for registered nurses and health care assistants: Pressure-ulcer-core-curriculum.pdf(nationalwoundcarestrategy.net)
- training and development plans and records, for example inductions, e-learning, completion of competencies, safety briefs, conference or study day attendance
- staff competency and capabilities frameworks, for example for AHPs
- use of incident reports or significant event analysis to support training and education programmes. (Root cause analysis [RCA] example in resources section)
- consider organisational management and team meetings to review results of RCA and demonstrate clear action plan of how to implement outcomes of review
- evaluation of training needs and training programmes to be reviewed/updated in line with any national or local recommendations

- local or organisational education and training packages, for example prevention and management of pressure ulcers, training from the local tissue viability nursing service, or practice education teams and National recognised pressure ulcer classification tools
- evidence of appropriate and person-centred information and support for people at risk of developing, or receiving care for, pressure ulcers (and/or their representatives)
- consideration to be given to appropriate technology-enabled care, including pressure redistributing equipment and pressure mapping
- all organisations to adopt NHSi/NWCSP categorisation tool for identifying and describing pressure ulcers and ensure staff are trained and understand the terminology to have consistent reporting
- all staff to be aware of local reporting processes to the Jersey Care Commission [JCC] and which categories are reportable via JCC
- staff to be aware of local providers of care and how to refer or who to ask for help, escalation processes, raising Safeguarding concerns

Useful documents & suggested resources for this Standard

Jersey Care Commission for reporting information and Adult and Children's Standards
SPOR: Mon to Fri - office hours 01534 444440 | spor@health.gov.je
Escalation pathway when concerns raised
Generic reporting pathway when Pressure Ulcer present
Purpose T risk assessment
National Wound Care Strategy Programme: pressure ulcer categorisation
National Wound Care Strategy Programme: Education & Recommendations
Adult Safeguarding Decision Tool
Wounds-UK Journal & Best Practice Documents

STANDARD 3: Person Centred information and support

Standard Statement

Information and support are available for people with, or at risk of developing pressure ulcers and / or their representatives where appropriate.

(Aligns to JCC standards for Care Homes 1,3,5 and Home Care 1,2,3,7, Children and Family Community Standards 5, 7, 9 & 11, Children's Home Services 5, 6, 7, 8 & 11).

Rationale

Access to high-quality, reliable information on the prevention and management of pressure ulcers enables and supports informed choice. This reflects the principles of realistic medicine, which encourages people and their representatives to have meaningful discussions with health and social care professionals about their care and treatment. Information should be responsive to the needs of the individual and include the risks and benefits of accepting or declining treatment.

Criteria	
People with, or at risk of developing, pressure ulcers (and/or their representatives) are provided with support and information in a format appropriate to their needs. This enables people to:	• discuss with health and social care professionals the risks and benefits of accepting or declining treatment • understand the impact, consequences and risks of developing pressure ulcers • make informed decisions about their care.
Information is provided in a range of formats and languages and covers:	• risk factors associated with pressure ulcers • how to prevent pressure ulcers • early identification of signs and symptoms of pressure ulcer development • how and when to report concerns and/or skin changes • strategies for the management of pressure ulcers, including self-management and appropriate equipment • wellbeing, including nutrition and maintaining active

What does the standard mean for people receiving care?

People:

- receive accurate and reliable information in a format and language that meets their needs, and which will enable them to make informed choices about their care and treatment
- can be confident that, where appropriate, their representatives will receive information and support that enables them to be involved in and informed about their care and support

What does the standard mean for staff?

Staff:

- are able to provide people (and/or their representatives) with information responsive to individual needs that is accurate and reliable and has been quality assured

What does the standard mean for the organisation/care providers?

Organisations:

- ensure staff can access high-quality information and support in a range of formats and languages
- support staff to provide bespoke information to individuals if standard formatting does not meet the individuals need

Practical examples of evidence of achievement

- information and support for people at risk of developing, or receiving care for, pressure ulcers (and/or their representatives), including information leaflets available in a range of formats and languages, text style, pictorial or audio. This may need to be personalised to the individual but core language in Jersey to include English, Portuguese and Polish
- shared care planning to demonstrate patient choice and decisions about their care are evident and in a format that the individual can access and understand

Health and Care Jersey

Family Nursing & Home Care

COMMUNITY PATHWAY
for escalation when concerns about actual or potential pressure ulcer

Do not assume level of involvement from other agencies
ALWAYS contact them for clarification or re-refer

Health professionals:

1. If not already known to FNHC, refer to FNHC community nursing team for assessment for prevention support and advice
2. If not already known to FNHC, refer to FNHC community nursing team for assessment and ongoing wound care
3. Consult with GP and ensure aware of concerns
4. If already known to FNHC consult with FNHC community nursing team with your specific concerns relating to pressure damage to ensure reviewed as the patient may not be seen regularly e.g. patient visited by a nurse 3 monthly for catheter care
5. Consider referring to SPOR for social work review, increased care needs/deteriorating condition, OT or physiotherapy input
6. Raise safeguarding concern if appropriate and refer to FNHC Tissue Viability team to seek help with Adult Safeguarding Decision tool completion
7. Consider an MDT or professionals meeting.

Concerned individual, family member and/or informal carers:

1. Ask a health or care professional for help or advice
2. Request referral to FNHC community nursing team
3. Self-refer to SPOR for social worker allocation if need assessment of care needs

Useful documents & suggested resources for this Standard
Jersey Care Commission for reporting information and Adult and Children's Standards
SPOR: Mon to Fri - office hours 01534 444440 | spor@health.gov.je
Local and organisational Escalation pathway when concerns raised
Safeguarding Partnership Board
Generic reporting pathway when pressure ulcer present
Shared care planning with all agencies involved in care
Information leaflets in key languages used locally – may need to individualise or use a translator

STANDARD 4: Initial assessment of risk of developing a pressure ulcer

Standard Statement

An initial risk assessment is undertaken as part of admission to, or first contact with, a care service to inform care planning.

(Aligns to JCC Standards for Care Homes 3, 5, 11, 12 and Home Care 2,3,4,5 & 6, Children and Family Community Standards 4, 5 & 8, Children's Home Services 10 & 11).

Rationale

Pressure ulcers can develop and deteriorate quickly, particularly in people considered to be at high risk. Those at high risk include babies, people with frailty, limited mobility or diabetes and those who have increased skin moisture, are nutritionally compromised or at end of life. A person may also be at risk of developing device-related pressure ulcers.

The aim of a risk assessment is to prevent and reduce the likelihood of developing pressure ulcers or the further deterioration of any existing pressure ulcers.

Structured and validated risk assessment tools are used to support professional and clinical judgement.

Risk assessments should be undertaken as soon as possible within the timeframes identified for each setting and according to the needs of the person and the care setting. There should be clearly defined local timeframes with referral and escalation policies. The assessments should consider the risk of pressure damage developing within a short time of an individual becoming immobile or acutely unwell. This information should be shared appropriately across care settings and teams.

Risk assessment needs to take into consideration any Safeguarding concerns and they need to be escalated through the relevant processes for the different organisations on Island, this includes members of the public being able to escalate any concerns to Safeguarding Partnership Board (SPB) themselves. Health professionals are advised to complete the Adult Safeguarding Decision Tool to guide practice or for children referral to the Child and Family Hub. The SPB decide if a concern reaches the threshold for further action and intervention.

Criteria

A structured and validated risk assessment tool is used to support professional and clinical judgement. The NWCSP recommends using Purpose-T and this is suitable for all ages (with a modified paediatric version available).

Assessment and documentation of the risk of developing pressure ulcers or further damage to existing pressure ulcers is carried out based on professional and clinical judgement as soon as possible after admission to, or contact with, the care service.

Where an assessment of risk or skin inspection has not been undertaken within the agreed timeframes staff must record within the person's care plan:	• the reason(s) assessment or inspection has not been undertaken or was delayed, including where request or referral has been sought for additional or specialist advice • the discussion with the person (and/or their representative) • any agreed actions

Each formal assessment is undertaken by appropriately trained and competent staff and requires patient consent or to be acting in their best interests if unable to consent:

- inspection of the person's skin, particularly areas over bony prominences and areas in contact with equipment and devices
- Be aware that skin tone can influence ease of detection of changes
- assess risk and other contributing factors e.g.: frailty, pain, limited mobility, diabetes, as per risk assessment tool
- assessment of the person's specific needs within their home or care setting,
- assess specific positioning ability and needs as well as equipment
- identification of self-management and self-assessment strategies for people (and/or their representatives)
- schedule planned review of care plans and reassessment of risk

For people assessed as having no current pressure damage, but who may be at risk of developing a pressure ulcer, refer to:

Standard 6: Care planning for prevention of pressure ulcers.

For people with an identified pressure ulcer(s), refer to:

Standard 7: Assessment, grading and treatment care planning for identified pressure ulcers. for prevention of pressure ulcers.

Anyone presenting with a foot ulcer(s) and diabetes should be referred immediately to the diabetes multidisciplinary team/diabetic podiatry service for specialist assessment.[16,17.]

Podiatry Triage Timeframe

1= Urgent Within 24-48 hours (where patient transport allows, if required)

- Active foot ulceration
- Suspected Charcot
- Ischaemia/gangrene/necrosis
- Acute onychogryphosis (Private podiatrist if no risk factors)

2 = Soon 2-4 weeks

- Biologics + life-limiting pain, no ulcer
- Orthotic referral + life-limiting pain + risk factors
- Significant bony deformity + risk factor
- Callus/nail pathology + risk factor
- Charcot Marie Tooth

3 = Routine 4-12 weeks where no other risk factors are identified

- Rheumatoid Arthritis with managed pain
- Orthotic referral
- Verrucae + risk factors
- Learning Disability/Vulnerable

What does this mean for the people receiving care?

People:

- are assessed to identify their risk of developing a pressure ulcer
- will have an initial pressure ulcer risk assessment when they are admitted or at their first contact with a health or care service, are asked about their health, for example any new or existing health problems, their eating habits, any problems with their bladder or bowel function, or restrictions to their movement
- will have a body map/skin inspection, with their consent, to identify changes in skin colour, numbness or pain around the bony areas of their body
- are assessed to review any equipment, such as cushions, seating or mattresses, they may use within their home or care setting to make sure it meets their needs
- will be advised as to how they can prevent pressure ulcers or treat existing ones
- are involved in agreeing a plan to review their treatment or reassess their risk
- are listened to and have confidence that their concerns will be acted upon when they report skin changes or raise concerns about their care
- will be supported to self-examine and self-manage skin integrity and care where able have their own responsive and age-appropriate care plan developed that reflects their needs and wishes and have a copy in a format that they find readable can be confident that, where appropriate, their representative will be involved in their risk assessment

What does this mean for staff?

Staff:

- demonstrate skills and competence relevant to their role in pressure ulcer risk assessment
- undertake an initial pressure ulcer risk assessment when a person is admitted or has first contact with a health or care service
- if the skin assessment is not possible, they clearly document why and what action is to be taken and when this is to be completed by
- know how and when to access specialist advice and teams for support to assess risk, if unsure to escalate to line manager for help
- participate in, and identify opportunities for, improvement work to assess and reduce the risk of developing pressure ulcers
- demonstrate good record keeping in line with local and professional standards

What does this mean for organisations/ health care providers?

Organisations:

- have policies and procedures for the timely assessment of risk on admission or first contact, for example:
    - within a maximum of 6 hours of admission to a hospital, hospice or care home
    - within a maximum of 24 hours of admission to any other care setting,
    - on a practitioner's first visit as part of any community service or team, for example community nurse, hospital at home, social care or care at home

- if not on first contact or within time frame ensure it is clearly documented why this was not carried out
- have locally or organisationally agreed risk assessment tools, it is recommended to use Purpose T across all areas
- follow pathways for appropriate referral processes and access to specialist advice and teams, with clear timeframes for responses noted
- have governance and reporting systems to ensure safe, effective and person-centred risk assessment, and to monitor adherence to relevant local protocols
- use clear guidance on staff roles and responsibilities in assessing risk, care planning, referral and escalation processes
- safeguarding consideration of raising alert and escalation process

Practical examples of evidence of achievement

- use of structured risk assessment tools, PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) is recommended by NWCSP
- care plans which demonstrate a multidisciplinary and person-centred approach to risk assessment, review and evaluation
- care plans which document reasons for non-concordance, for example incapacity, the person is acutely unwell or refuses a skin inspection
- use of other standards and assessment tools to support care planning, for example: continence assessment, pain assessment, frailty assessment, comprehensive geriatric assessment, falls risk assessment, 4 AT rapid clinical test for delirium, Malnutrition Universal Screening Tool (MUST) and Paediatric Yorkhill Malnutrition Score (PYMS), assessing for specialist equipment needs, consider OT and physiotherapy input
- implementation and review of pathways for specialist referral and escalation, including seating assessment and guidance and equipment assessment and recommendations
- any safeguarding concerns: Child and Family Hub for children in community, Safeguarding team in-patient setting, SPB for advice, Adult Safeguarding Decision tool & raising safeguarding alert
- improvement tools to test, implement and review measurement and monitoring tools
- data collection, monitoring and review, with appropriate action where necessary
- output of the organisation's governance/reporting system for reviewing risk assessment
- awareness of escalation process if pressure ulcer found or concerns regarding capacity
- capacity and decision-making assessment
- care needs changing and review of package of care needed
- social worker & SPOR referral
- professional or Multi-Disciplinary Team meeting to discuss needs and action plan
- moving and handling assessment

Useful documents & suggested resources for this Standard

JCC website: https://carecommission.je/ - reporting information and Adult and Children's Standards
SPOR: Mon to Fri - office hours 01534 444440 spor@health.gov.je
Local and organisational Escalation pathway when concerns raised
Safeguarding Partnership website Safeguarding Partnership Board
Pressure Ulcer Clinical Pathway (Appendix 1)
Shared care planning with all agencies involved in care
Information leaflets in key languages used locally – may need to individualise or use a translator

Standard Statement

Regular reassessment is used to re-evaluate an individual's risk of developing pressure ulcers or experiencing further damage to existing pressure ulcers.

(Aligns to JCC Standards for Care Home 1,2,6 &12 and Home Care 1,2,5 & 9, Children and Family Community Standards 4 & 10, Children's Home Services 10 & 11).

Rationale

Regular reassessment of risk is essential for the ongoing prevention and management of pressure ulcers and can prevent further damage to existing pressure ulcers. Risk reassessment should be carried out when a person becomes acutely unwell or immobile, has a fall or following a medical procedure or any deterioration in their baseline.

Regular reassessment ensures that any changes in a person's circumstances are recorded and used to inform care plans. Robust documentation and regular review also ensure that a person's care plan is safe, effective and person-centred.

Reassessment, undertaken alongside the evaluation of existing care plans, also identifies whether existing interventions are managing the risk appropriately. It is important to note that there will not always be changes to the risk assessment score, particularly for people already identified as high risk, despite further changes or deterioration of existing pressure ulcers (see Standard 4).

The timing of reassessment should be agreed with the person, in accordance with local guidance, and may be indicated during the initial risk assessment, it should be flexible and carried out according to clinical need.

Criteria

A structured and validated risk assessment tool is used to support professional and clinical judgement for each reassessment, Purpose T is recommended.

Regular reassessment of risk is undertaken, using a structured and validated tool (see Standard 4) when:	• an observed or reported change has occurred in the person's condition or changes are noted upon skin inspection • the person (and/or their representative) reports a change • the person is transferred to another location or care setting within the same organisation • where appropriate, the person-centred care plan is then revised (see Standards 6 and 7)
Where a person's care plan has not been implemented or followed, staff record within the care plan:	• the discussion with the person (and/or their representative) • any agreed actions: consider Safeguarding alert or discussion with Safeguarding team, consider any change in capacity and decision making, acting in person's best interests • the reason care has not been delivered, such as the person's informed choice, declined by person or where there is no access to specific services

For people assessed as having no current pressure damage, but who may be at risk of developing a pressure ulcer, refer to **Standard 6: Care planning for prevention of pressure ulcers.**

For people with an identified pressure ulcer(s), refer to **Standard 7: Assessment, grading and treatment care planning for identified pressure ulcers. for prevention of pressure ulcers.**

What does the standard mean for people receiving care?

People:

- are asked about their health, including problems with their bladder or bowel function, their eating habits and any changes to their mobility
- are examined, with their consent, to identify changes in skin colour, numbness or pain around the bony areas of their body
- are assessed to review any equipment they might use, for example seating, and their environment to make sure it meets their needs
- are advised on how they can help prevent pressure ulcers or improve existing pressure ulcers
- are given opportunities to discuss plans to review any treatment or to undertake a reassessment, and to develop or review their care plan
- are supported to self-examine and self-manage their skin integrity and care where able
- can be confident that, where appropriate, their representatives will be involved in their risk reassessment
- offered support and information on how to access relevant services and financial advice if required

What does the standard mean for staff?

Staff:

- understand their role and responsibilities in the reassessment of risk for pressure ulcers and evaluation of care plans in line with local policies and procedures
- can demonstrate knowledge, skills and competence relevant to their role in pressure ulcer risk reassessment
- are confident about factors that may trigger risk reassessment, for example people at the end of life or with frailty or sepsis, changes in nutritional intake or mobility, an acute illness episode or following a medical procedure or use of new medical equipment
- know how and when to access specialist advice and teams that support reassessment of risk and care planning, escalate to manager/team lead if uncertain of process or action to be taken
- participate in improvement work to assess and reduce the risk of further deterioration or development of pressure ulcers and to identify opportunities for improvement
- demonstrate good record-keeping in line with local and professional standards
- to have had relevant education and training to equip with necessary knowledge and skills to undertake the assessment/reassessments

What does the standard mean for the organisation/care providers?

Organisations:

- have guidance available for reassessment of risk, including timings and criteria for referral or transfer between care settings
- demonstrate effective referral and access to specialist teams
- have clearly defined staff roles and responsibilities for reviewing pressure ulcer risk
- ensure staff have access to relevant training and education to be able to undertake the assessment/reassessments
- to support staff to be confident and competent in these skills and offer additional help if requested to meet the required competencies

Practical examples of evidence of achievement

- policies and procedures for the management of high-risk individuals, for example end of life care, sepsis and frailty
- use of risk assessment tools it is recommended to use Purpose T
- monitoring and reporting of reassessment and evaluation of care plans
- person-centred care plans demonstrating reasons for non-concordance, strategies to improve and actions taken
- use of improvement and measurement tools to monitor reassessment of risk
- action plans for scheduling reviews
- training plans and updates in place for all levels of staff
- scheduling tools/diary/calendar to ensure reassessment are appropriately scheduled and completed

Useful documents & suggested resources for this Standard
Jersey Care Commission for reporting information and Adult and Children's Standards
SPOR: Mon to Fri - office hours 01534 444440 | spor@health.gov.je
Local and organisational Escalation pathway when concerns raised
Safeguarding Partnership Board
Generic reporting pathway when Pressure Ulcer present
Shared care planning with all agencies involved in care
Information leaflets in key languages used locally – may need to individualise or use a translator
Skin check scheduling - aSSKINg & Safeguarding
Capacity and decision making to be considered

Standard Statement

A person-centred care plan is developed and implemented to reduce the risk of developing pressure ulcers.

(Aligns to JCC Standards for Care Home 1,2,6 & 12 and Home Care 1,2,5,7 & 9, Children and Family Community Standards 4, 5, 6, 7 & 11, Children's Home Services 7, 10, 11 & 13)

Rationale

Person-centred care planning supports the prevention of pressure ulcers in anyone at risk of developing pressure ulcers. The care plan is based on the outcomes of risk assessment and professional and clinical judgement, considering risk factors and informed personal choice. Where appropriate, the person's representative will also be involved.

Preventative strategies, such as the aSSKINg Framework underpin high-quality care. These should be initiated when a person is at risk of developing a pressure ulcer. Preventative strategies should also include support and information for the person, and/or their representative, to self-manage their risk of developing pressure ulcers.

The delivery of safe, effective and person-centred care should be supported by locally agreed policies and processes. These should include criteria and timings for referral or liaison with specialist teams, such as dietetics, tissue viability service, vascular service, AHPs and pain management services.

We must consider that not everyone will accept the recommendations made for their care, we must respect when individuals make their own decision that is not necessarily in line with those of the health professionals. We do need to consider capacity and decision-making ability, but we do not have the right where there is no question of their capacity to enforce care. This is especially true when applied to dignity and privacy of checking skin and asking them to expose parts of their body to be checked. We must ensure we give the person all of the information they need to make an informed decision even if they then decline to engage with the recommendations, this can be any aspect of their care, for example, sitting for long periods of time, inappropriate footwear, poor nutrition and hydration all have potential impacts on quality of life and risk but they are not necessarily our choices to make.

Criteria	
The person-centred care plan is agreed with the person (and/or their representative), 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 or nutritional compromise (aSSKINg care bundle) • frequency of repositioning • frequency of skin inspection • requirements for equipment • skin cleansing and maintenance regime • cross-references to other relevant care plans, such as falls risk or nutrition. • details of self-management strategies and information • planned reassessment of risk and care plan.
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

For people with an identified pressure ulcer(s), refer to

Standard 7: Assessment, grading and treatment care planning for identified pressure ulcers. for prevention of pressure ulcers.

What does the standard mean for people receiving care?

People:

- are involved in developing their own care plan, which is informed by their needs and wishes, as well as professional judgement
- are advised of ways to prevent skin damage, such as how often to change their position or how to look after their skin
- are assessed by health and social care professionals to help manage possible contributing factors to developing pressure ulcers, including:
    - bowel and bladder function
    - nutrition and hydration
    - pain
- have their equipment needs assessed to determine whether specific items, for example special mattresses or devices, will help redistribute pressure on their skin
- where equipment is provided, people will be supported to ensure they are confident using it and know who to contact to report any issues or concerns
- receive information on diet and fluid intake
- can be confident that, where appropriate, their representative will be involved in their care planning

What does the standard mean for staff?

Staff:

- are able to develop, implement and review care plans throughout the person's care and treatment
- ensure all relevant documents are accurately completed and shared to support the continuity of care within and across care settings and professional groups
- know how and when to access specialist advice and teams that support care planning
- demonstrate an awareness and competence to assess and implement action plans to reduce the risk of developing pressure ulcers
- demonstrate an awareness of improvement work to assess and reduce the risk of developing pressure ulcers
- demonstrate good record-keeping in line with local and professional standards

What does the standard mean for the organisation/care providers?

Organisations:

- have clear guidance on roles and responsibilities for person-centred care planning, including referral for specialist advice, treatment and equipment
- ensure systems are in place to enable the appropriate sharing of information and care plans throughout the person's care and treatment
- monitor data and undertake learning to improve care planning and sharing of information, particularly across care settings
- ensure staff can access and attend relevant training and education to enable them to meet the required competency and educational standards to provide care

Practical examples of evidence of achievement

- provide information for people at risk of developing pressure ulcers (and/or their representative) and that it is responsive to an individual's need
- staff are seen to create effective person-centred care plans demonstrating prevention and treatment strategies
- documentation of skin care that includes personal hygiene, undertake body mapping and record any damage or areas of concern, photographs (with the person's consent) or aSSKINg care bundle
- person-centred care plans that record reasons for non-concordance, strategies to improve and actions taken
- timely communications between health and social care staff, for example discharge summaries to GPs, admission letters from care homes and referral or escalation to specialist teams
- consider the need for professionals meeting or multi-disciplinary meeting to discuss/raise concerns so that all parties have relevant and appropriate information and are aware of actions, interventions and risk levels
- consideration of safeguarding referrals, decision making and capacity assessments
- documented evidence of discussion with the individual, their family/carers/representative (where appropriate) and the recommendations, the response of the person and others involved in care and the outcome
- use of other standards and assessment tools in care planning, such as comprehensive geriatric assessment, MUST, bladder and bowel assessment

Podiatry Triage Timeframe (refer to standard 4)

Useful documents & suggested resources for this Standard
Jersey Care Commission for reporting information and Adult and Children's Standards
SPOR: Mon to Fri - office hours 01534 444440 | spor@health.gov.je
The aSSKINg Framework
Escalation pathway when concerns raised
Generic reporting pathway when Pressure Ulcer present
Jersey Wound Care Dressing Products formulary. For non HCJ follow link to the current FNHC Wound Dressing Formulary.
Wound assessment, measurement and photography
Skin checks and positioning scheduling – frequency and escalation if concerns Onward referral to GP, TVNs, surgical team, diabetes team, physiotherapy, occupational therapy
Consideration of equipment needs and seating assessment

Standard Statement

People with identified pressure ulcers will receive a holistic assessment and experience high quality and person-centred treatment and support.

Aligns to JCC Standards for Care Home 2, 3, 4, 5, 6, 9, 10 11 & 12 and Home Care 1,2, 3, 4, 5, 6, 7, 8 & 9, Children and Family Community Standards 4, 5, 6, 7, 9 & 11, Children's Home Services 6, 7, 10, 11 & 12).

Rationale

A holistic assessment considers the person's health and wellbeing needs, the care setting and any equipment and support required for self-management. A holistic assessment ensures that a person-centred treatment care plan is developed and implemented.

Where appropriate, the person's representative will also be involved in the assessment and care planning.

Each person's assessment will include a comprehensive wound assessment and pressure ulcer categorisation. There are recognised tools to support assessment and categorisation of pressure ulcers, assessment of wounds and identification of wound infection. Health and social care professionals should seek to minimise variance in the assessment of pressure ulcers using validated tools: NHSI pressure ulcer categorisation tool and Purpose T are recommended.

Pressure ulcers which are categorised as 2 or above are reported to the JCC. Staff should follow the JCC process for notifying them of incidents, advice is available on the JCC website. Additionally, organisations should undertake reviews of these incidents to identify the cause of the pressure ulcer, identify learning and actions to prevent in the future and any actions are noted in patient record, implemented and any additional outcomes.

Regular assessment is required to monitor the person's condition (and any potential deterioration of existing pressure ulcers) and any changes in their health (including potential infection or sepsis), wellbeing and personal circumstances.

Criteria	
Everyone with identified pressure ulcers will receive a holistic assessment. **This will be completed by an appropriately trained health or social care professional.**	• undertake a pressure ulcer assessment, which includes categorising the pressure ulcers, using validated NHSI categorisation tool and NWCSP guidance • complete a holistic wound assessment using validated structured tools • develop and implement a person-centred treatment plan for pressure ulcer management, with an identified review period and cross-reference to other relevant care plans, including nutrition and risk of falls • assess the requirement for equipment and dressings or therapies to assist in the management of pressure ulcers and prevention of further skin breakdown • develop a skin cleansing and maintenance regime • carry out regular assessment of pressure ulcers • escalate any concerns through the local reporting process • demonstrate good record-keeping
Where not appropriately trained and competent health and social care professional is available the person finding the skin damage must make:	• a referral for a review is made to an appropriately trained member of staff (FNHC for community, consider HCJ TV team for HCJ care provision), to undertake pressure ulcer assessment, categorisation and care planning • escalate concerns to a GP, social worker or other HCP and that this is recorded appropriately
For all pressure ulcers that have developed while a person is in a care setting or is receiving care in their home, a review is undertaken with appropriate investigation, identification of learning and reporting of actions implemented, as part of ongoing improvement. When a person has been transferred between care settings with existing pressure ulcers, the referring service must be notified at time of transfer so they can undertake an appropriate review on the arrival of that person into their care.	
A referral to a specialist is made in accordance with local policy, for example if there is deterioration, poor healing, signs of infection or sepsis, or vascular compromise.	
Anyone presenting with a foot ulcer and diabetes is referred by the person finding the wound to the diabetes multidisciplinary team or diabetic podiatry service for specialist assessment. The diabetes multidisciplinary team or diabetic podiatry service have a triage pathway.	

Podiatry Triage Timeframe (refer to standard 4)

What does the standard mean for people receiving care?

People:

- are asked about their general health and wellbeing
- have their pressure ulcers examined and, where appropriate and with their consent, photographed for their health records, this can be done on a work device and deleted once uploaded to medical record
- can discuss with the HCP or carer how their pressure ulcers will be treated and managed, for example with dressings, pain relief and equipment
- are listened to by staff who will act on any concerns they may have about their pressure ulcers
- can be confident that, where appropriate, their representative will be involved in their assessment, grading and care planning

What does the standard mean for staff?

Staff:

- understand their role and responsibilities in relation to the prevention and management of pressure ulcers and the requirement to escalate or refer to a specialist where appropriate
- access relevant tools and documentation to support a comprehensive wound assessment
- demonstrate good record-keeping in line with local and professional standards
- effectively share and communicate information with the individual, their representative and other staff involved in their care
- implement effective management of pressure ulcer strategies, including supporting people to effectively self-manage their pressure ulcers

What does the standard mean for the organisation/care providers?

Organisations:

- ensure systems are in place to enable safe, effective, person-centred communication and management of information across teams and care settings
- provide clear guidance on staff roles and responsibilities for assessing, grading, care planning, referral and escalation processes, including timeframes
- ensure pathways are available to support referral to specialist healthcare professionals where required
- facilitate ongoing monitoring of acquired pressure ulcer incidents and data and undertake appropriate actions to learn from and reduce the incidence of pressure ulcers

Practical examples of evidence of achievement

- use of wound assessment and categorising tools, risk assessment tools, photographing of wounds (basic SOP in resources)
- local dressing formulary and guidance for wound cleansing and management
- pathways for referral to registered healthcare professionals for further assessment
- effective care plans demonstrating management and treatment options, reassessment and progress of care
- monitoring of data relating to pressure ulcer grading and incorporating data into improvement plans
- use of improvement tools and incidence data to reduce the incidence of pressure ulcers
- communications demonstrating multidisciplinary working, for example discharge summaries, referral letters and clear handover plans between professionals in health and social care settings
- timely communications between health and social care staff, for example discharge summaries to GPs, admission letters from care homes and referral or escalation to specialist teams

Useful documents & suggested resources for this Standard

Jersey Care Commission for reporting information and Adult and Children's Standards
SPOR: Mon to Fri - office hours 01534 444440 | spor@health.gov.je
Generic reporting pathway when Pressure Ulcer present
Jersey Wound Care Dressing Products formulary For non HCJ please follow link to the current FNHC Wound Dressing Formulary.
Wound assessment, measurement and photography
Skin checks and positioning scheduling – frequency and escalation if concerns Onward referral to GP, TVNs, surgical team, diabetes team, physiotherapy, occupational therapy
Consideration of equipment needs and seating assessment
JCC Notifications Guidance 2024


SAFEGUARDING
IS EVERYONE'S
RESPONSIBILITY.
IT'S NOT A CHOICE.

Safeguarding and pressure ulcers are closely linked, especially in the context of healthcare and social care settings. Where pressure ulcers do occur, The Island-Wide Pressure ulcer

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

'Remember, never do nothing'

Prevention and Management Framework provides a clear process for the clinical management of the removal and reduction of harm to the individual, while considering if an adult safeguarding response is necessary. Safeguarding underpins all 7 standards.

The Department of Health & Social Care document; 'Safeguarding adults' protocol: pressure ulcers and raising a safeguarding concern' [9]. provides a national framework for health and care organisations to draw on when developing guidance for staff in all sectors and agencies that may see an individual with a pressure ulcer. It is not the remit of this framework to provide these for the different organisations.

The first priority is to ensure the safety and protection of the adult at risk.

- all staff and volunteers from any service or setting should know about the Safeguarding Adults Procedures
- each organisation/care provider is responsible for ensuring that they have their own policy/guidance/procedures to follow as well as local legislative processes (Safeguarding Partnership Board and JCC) when raising or reporting concerns. It is not the remit of this Framework to provide these for the different organisations
- employees will need to read their workplace policies and procedures for safeguarding which will provide information on the steps to follow in reporting concerns of abuse
- It is good practice for workplaces to have a designated safeguarding lead, in health and social care settings this is often the manager

Pressure ulcers may occur as a result of neglect. Neglect may involve the deliberate withholding or unintentional failure of a paid, or unpaid, carer to provide appropriate and adequate care and support.

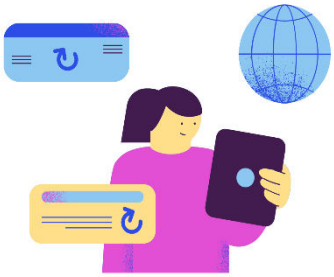
The Making Safeguarding Personal (MSP) approach means to engage people in conversations to create bespoke person-centred solutions that enhance their involvement, choice, and control; with the aim of improving their circumstances, wellbeing and safety. [24]

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 is more effective when we work together cooperatively.

“In Jersey, we endorse the ethos of making no decision about me, without me.”

The website for Jersey Safeguarding Partnership Board has useful contacts, resources and forms to support you with your concerns. Visit the Safeguarding Partnership Board Website.

GUIDANCE | JERSEY SAFEGUARDING PARTNERSHIP BOARD



FORMS | JERSEY SAFEGUARDING PARTNERSHIP BOARD

USEFUL LINKS | JERSEY SAFEGUARDING PARTNERSHIP BOARD

Severe damage in the case of pressure ulcers may be indicated in some cases by multiple category 2 or single category 3 or 4 ulcers but could also be indicated by the impact the pressure damage has on the person affected (for example, pain).

It is recognised that severe pressure ulcer damage can already be present and yet not visible on the skin. Therefore, it is important to be vigilant for anything that indicates damage to the skin or underlying tissues, most commonly reports of pain or numbness, then changes in the tissue texture or turgor (rigidity), change in temperature and finally changes in colour - remembering that not all skin tones show redness.

If a staff member is concerned that the pressure ulcer may have arisen because of poor practice, neglect or abuse, or an act of omission they should:

- complete the adult safeguarding decision guide (see Appendix 3 for example)
- raise an incident immediately as per organisation policy

The role of health professionals

All healthcare professionals who provide care within their services have a responsibility for raising concern's. They must have an awareness of who to report to and how to report their concerns.

if they feel there is a potential safeguarding issue, health professionals should complete:

Safeguarding decision guide assessment questions

- the decision guide should be completed by a qualified member of staff who is a practising registered nurse (RN) with experience in wound management and not directly involved in the provision of care to the service user at the time the pressure ulcer developed. This does not have to be a tissue viability nurse
- the adult safeguarding decision guide should be completed immediately or within 48 hours of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension should be recorded
- the outcome of the assessment should be documented on the adult safeguarding decision guide. If further advice or support is needed with regards to making the decision to raise a concern to SAT, the safeguarding adults lead or the next most senior manager within the organisation should be contacted
- where the individual has been transferred into the care of the organisation it may not be possible to complete the decision guide. Contact should be made with the transferring organisation to ascertain if the decision guide has been completed or any other action taken

The safeguarding decision guide assessment considers 6 important questions that together indicate a safeguarding decision guide score. This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the pressure ulceration. It is not a tool to risk assess for the development of pressure damage. Appendix 4 gives example background questions to ask when completing the adult safeguarding decision guide.

The threshold for raising a concern is 15 or above in most instances. However, this should not replace professional judgement.

Following this, a decision should be made whether to raise a safeguarding adults concern.

Where there is no indication that a safeguarding concern needs to be raised the completed decision guide should be retained in the service user's notes.

Where the decision guide score is 15 or higher, or where professional judgement determines safeguarding concerns, The Adult Safeguarding Concern Form [23] should be completed.

Copies of the completed decision guide and safeguarding concern form should then be sent to the SPOR. Copies of both should also be retained in the service user's electronic or paper notes.

Please note that both the safeguarding concern form and decision tool are needed to send to the SPOR for the referral to be processed. Failure to do so will result in it being returned to you by SPOR.

A Root Cause Analysis (RCA) to establish the cause of injury (Appendix 5)

This is an essential part of the safeguarding enquiry, and an enquiry or partner report may also be requested by SAT, dependent on what is proportionate to the situation. The timescale for the enquiry officer is 20 working days.

Where possible The RCA should be sent with the decision guide assessment and the Safeguarding concern form, however it is appreciated that that the time frame to complete the RCA may exceed 48 hours.

The Safeguarding Adults Team (SAT) will become involved where neglect is indicated. Partner agencies with the relevant clinical skills and knowledge will be involved in relevant enquiries.

For pressure ulcer related matters, which are not judged to be caused through neglect, the Safeguarding Adults Team do not have a role.

The role of the Safeguarding Adults Team

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.

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.

(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
- any RCA or enquiry or partner report should be sent to the SAT
- 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

Children and safeguarding concerns

Children, whilst less likely to develop pressure damage, can still be at risk, especially if complex health needs or a home environment that has challenges. There is useful information relating specifically to children and young people on the Safeguarding Partnership Board website.

The timeframe for raising a safeguarding concern:

Stage 1	**Concerns**	Immediate action in cases of emergency, within one working day in other cases: Safeguarding Screening Stage Are there care/support needs? An adult with care and support needs may be: • a person with a physical disability, a learning difficulty or a sensory impairment • someone with mental health needs, including dementia or a personality disorder • a person with a long-term health condition • someone who misuses alcohol or substances to the extent that it affects their ability to manage day-to-day living. • someone who is unable to demonstrate the capacity to make a decision relating to their safety and is in need of care and support. Is any abuse happening or is likely to happen. What is abuse & how many types of abuse? There are 12 different types of abuse: 1. Physical abuse 2. Domestic violence or abuse 3. Sexual abuse 4. Psychological or emotional abuse 5. Financial or material abuse 6. Modern slavery 7. Discriminatory abuse 8. Organisational or institutional abuse 9. Neglect or acts of omission. 10. Self-neglect 11. Hate/Mate crime. 12. FGM Is unable to protect themselves because of their care and support needs. With the guidance taken from The Care Act 2014 (and interpreted for the Jersey context), the definition of an adult at risk applies in respect of any person aged 18:- (1) Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there): (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it If the referral MEETS the threshold and there is a completed safeguarding decision tool of 15 and SAT will become involved If the person DOES NOT meet the criteria of an “adult at risk” in line with the Adult Safeguarding Procedures, please advise the professional or person raising the concern that they should consider other ways to support the situation outside of the safeguarding procedures such as signposted to other agency, if necessary, e.g. if mental health issues, specific care needs
Stage 2 Enquiries	**Initial visit/conversation**	48 hours - if not already taken place
	Planning meetings	Within 5 working days
	Enquiry action	Target time within 20 working days
	Agreeing outcome	Within 5 working days of enquiry report
Stage 3 Safeguarding plan and review	**Safeguarding plan**	Within 5 working days of enquiry report
	Review	No more than 3 months, but dependent upon risk
Stage 4	**Closing the enquiry**	Actions immediately following decision to close where possible. Other actions within 5 working days

Reporting a Safeguarding Concern:

If You are concerned about a **CHILD**	If you are concerned about an **ADULT**
If you are concerned about a child please contact: **The Children and Families Hub** **PHONE** 01534 519000 **EMAIL** childrenandfamilieshub@gov.je	If you are concerned about an adult please contact: **Single Point of Referral (SPOR) for Adult Social Services** **PHONE** 01534444440 **EMAIl** spor@health.gov.je

OPENING TIMES

Monday – Thursday 08:30 – 17:00

Friday 08:30 – 16:30

DIRECT LINK

Report A Concern | Jersey Safeguarding Partnership Board

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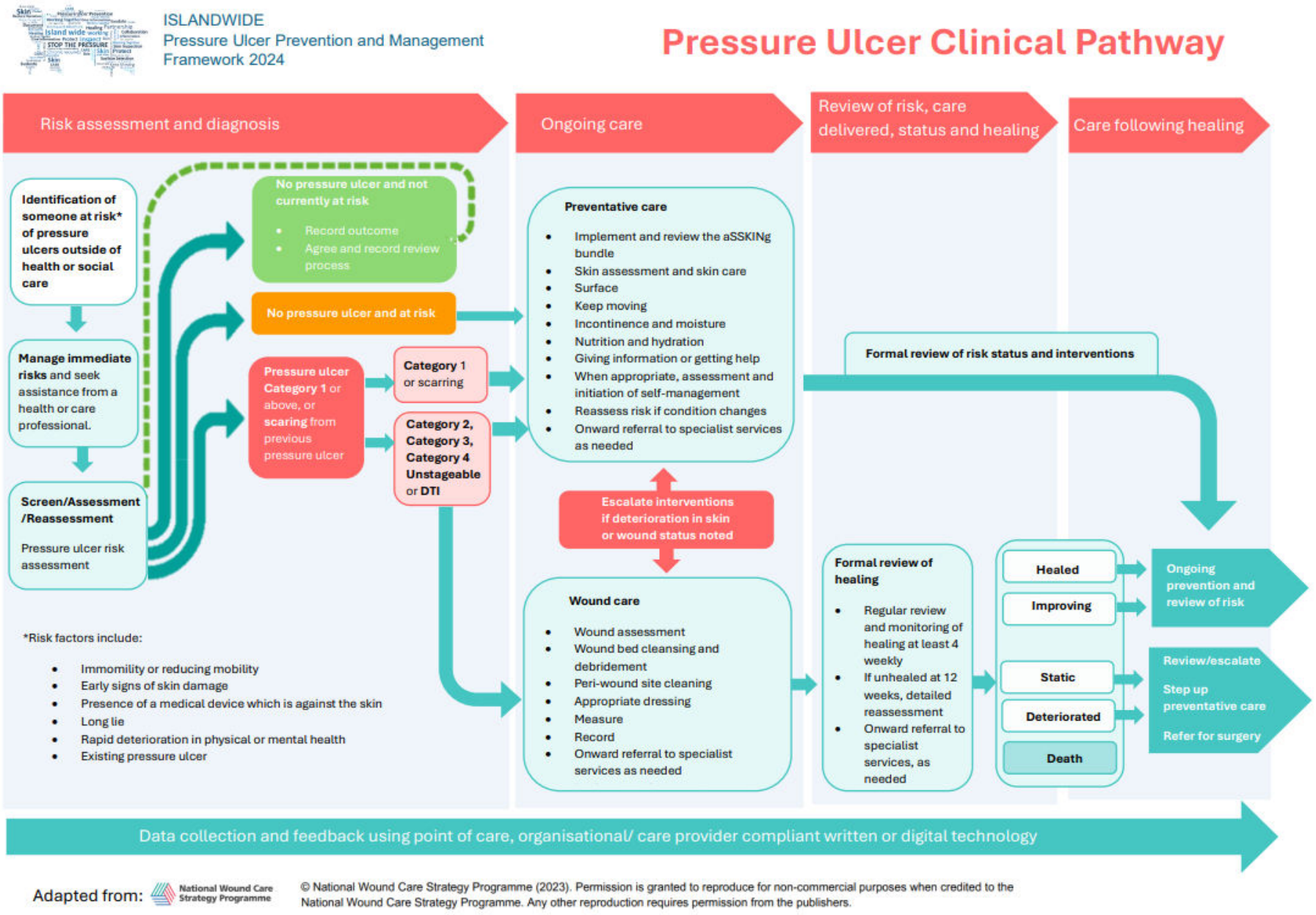
APPENDICES & RESOURCES

Appendix 1: Pressure Ulcer Clinical Pathway



Adapted from: National Wound Care Strategy Programme

Appendix 2: Pressure Ulcer Categorisation

Available at https://www.nationalwoundcarestrategy.net/wp-

Pressure ulcer categorisation

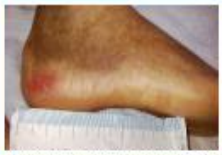
NHS

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).

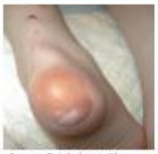
Category 2: Partial thickness skin loss

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

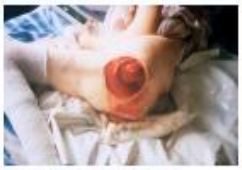
Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.

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.

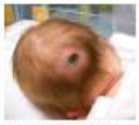
Category 4: Full thickness tissue loss

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

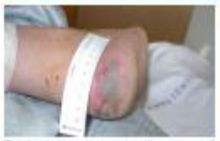
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.

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

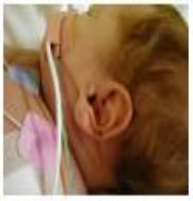


This heel ulcer appears as a linear area of deep purple black discolouration

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.



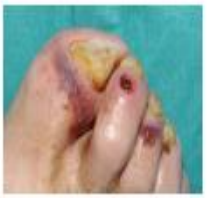
This infant has Category 1 damage to the cheeks and a small unstageable ulcer on the ear

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

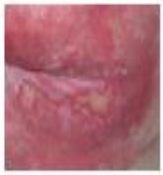
Damage has occurred where the spectacles and elastic from the oxygen mask press on the pinna of the ear



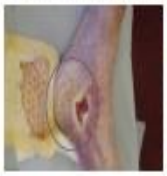
Although difficult to identify, this PU was caused by the patient having their feet caught in the bed sheets which were tightly twisted across the toes

Moisture-associated skin damage

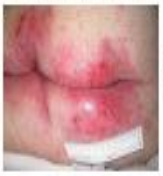
This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat



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".

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

Appendix 3: Adult Safeguarding decision guide

ADULT Safeguarding decision guide – PRESSURE ULCERS			
The adult safeguarding decision guide should be completed immediately or within 48 hours of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension should be recorded.			
You should review all 6 questions and provide supporting narrative in the evidence column highlight the score for each question in yellow - then calculate the total score			
Patients name		**URN**	
Date		**Time**	
1st Assessors name		**Signature**	
2nd Assessors name		**Signature**	

	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 or non- blanching erythema progressing to category 2 or category 2 progressing to category 3, 4 or unstageable.	5	For example, 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 soc[illegible]are 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?**	Change in [illegible]ndition contributing [illegible] skin dam[illegible]. E in[illegible]n), pyre[illegible]aemia[illegible]nd of life ca[illegible]e (s[illegible]n chan[illegible]at life en[illegible], cri[illegible]l illness, [illegible]ency hos[illegible]tal visit.	[illegible]	
		N[illegible]change in condition that cou[illegible]contribute to skin damage.	5	
3	**Was there a pre[illegible]ure ulce[illegible]isk assess[illegible]or [illegible]assessm[illegible]t with [illegible]ppropriat[illegible]ure ul[illegible]r care plan i[illegible]place and [illegible]ocumen[illegible]ed? In [illegible]e with each [illegible]an[illegible]tions pol[illegible]y and gu[illegible]nce.**	**YES,** Current risk assessment and care plan carried out by a health care professional and documented appropriate to patient's needs.	0	State date of assessment, risk tool used and score or risk level
		YES, Risk assessment carried out and care plan in place documented **but** not reviewed as person's needs have change.	5	State the elements of care plan that are in place
		No or incomplete risk assessment and/or care plan carried out.	15	State the elements that 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 plan.			
a	**Was the patient compliant with the care plan having received information regarding the risks of non-compliance?**	Patient has not followed care plan and local non-Concordance policies have been followed.	0	
		Patient followed some aspects of care plan but not	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 interests assessments and record of care delivered)**	Documentation of care being undertaken in patient's best interests	0	
		No documentation of care being undertaken in patient's best interests	10	
	TOTAL SCORE			

If the score is **15** or over, discuss with the 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 reporting 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.

Adapted from DOH adult safeguarding decision guide following consultation with Jersey Safeguarding Partnership Board. DOH_Pressure-ulcers-safeguarding-adults decision tool updated -march-2024.odt

Appendix 4: How to complete the safeguarding decision guide

Use the following criteria when completing the adult safeguarding decision guide for individuals with severe pressure ulcers.

History

Include any factors associated with the person's behaviour that should be taken into consideration - for example, sleeping in a chair rather than a bed.

Medical history, ask questions such as:

Does the person have a long-term condition or take any medication which may impact on skin integrity? For example, rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), chronic oedema or steroid use.

Is the person receiving end of life care?

Does the person have any mental health problems or cognitive impairment which might impact on skin integrity? For example, dementia or depression.

Monitoring of skin integrity, ask questions such as:

Were there any barriers to monitoring or providing care - for example, access or domestic or social arrangements?

Should the illness, behaviour or disability of the person have reasonably required the monitoring of their skin integrity (where no monitoring has taken place prior to skin damage occurring)?

Did the person decline monitoring? If so, did the person have the mental capacity to decline such monitoring?

Were any further measures taken to assist understanding? For example, person's information, leaflets, ward leads, team leader and senior nurses?

If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?

Were there any other notable personal or social factors which have affected the person's needs being met? For example, history of self-neglect, lifestyle choices and patterns, substance misuse, unstable housing, faith, mental ill health, learning disability.

Expert advice on skin integrity, ask questions such as:

Was appropriate assistance sought? For example, professional advice from a community nurse, clinical lead or tissue viability specialist nurse.

Was advice provided? If so, was it followed?

Care planning and implementation for management of skin integrity.

Ask questions such as:

Was a pressure ulcer risk assessment carried out upon entry into the service and reviewed at appropriate intervals?

If expert advice was provided, did this inform the care plan?

Did skin integrity assessment and monitoring at suitable and appropriate intervals form part of the care plan?

Were all of the actions on the care plan implemented? If not, what were the reasons for not adhering to the care plan? Were these documented?

If the person has been assessed as lacking the mental capacity to consent to the care and treatment in the care plan, has a best interest decision been made that care and treatment delivered is in their best interests?

Did the care plan include provision of specialist equipment?

Was the specialist equipment provided in line with local timescales?

Was the specialist equipment used appropriately?

Was the care plan revised within time scales agreed locally?

Care provided in general (hygiene, continence, hydration, nutrition, medications), ask questions such as:

Does the person have continence problems? If so, are they being managed? Are skin hygiene needs being met (including hair, nails and shaving)? Has there been deterioration in physical appearance?

Are oral health care needs being met?

Does the person look emaciated or dehydrated?

Is there evidence of intake monitoring (food and fluids)?

Has the person lost weight recently? If so, is the person's weight being monitored?

Are they receiving sedation? If so, is the frequency and level of sedation appropriate?

Do they have pain? If so, has it been assessed? Is it being managed appropriately?

Other possible contributory factors, ask questions such as:

Has there been a recent change (or changes) in care setting or circumstances?

Is there a history of falls? If so, has this caused skin damage? Has the person been on the floor for extended periods? Has the person been seen by the ambulance service, even if not sent to hospital?

Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK

Appendix 5 Root Cause Analysis - Pressure Ulcer - Template

Patient's name		**Age and DOB**	
Completed by		**Date of completion**	

ASSESSMENT AND FINDINGS

1	Date pressure ulcer detected/date of deterioration of ulcer detected					
2	Where was the person when the pressure ulcer was detected					
	Where was the person when the pressure ulcer developed					
3	Current Purpose T risk rating	Red	Amber	Green	Date	
4	Previous Purpose T risk rating	Red	Amber	Green	Date	
5	Location and size of pressure ulcer (s)					
6	Category of pressure ulcer (s)					
7	Reason for contact with person					
8	Outline any relevant past medical history					
9	Has a movement and handling assessment been carried out? (circle 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? (circle as appropriate)				Yes	No
13	Has there been a change in medical condition? (circle as appropriate)				Yes	No
	If yes, to 12 &/or 13 explain briefly.					
14	Were reasonable steps taken to prevent skin damage? (circle as appropriate)				Yes	No
	Please record name and type of equipment being used					
	• Appropriate pressure relieving mattress (circle as appropriate)				Yes	No
	• Regular turning (circle as appropriate)				Yes	No
	• Heel protectors(circle as appropriate)				Yes	No
	• Pressure relieving cushion (circle as appropriate)				Yes	No
	• Regular skin checks (circle as appropriate)				Yes	No
	Other (please specify)					
15	Were the pressure areas monitored regularly? Detail how often checked:				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? **Complete Adult Safeguarding decision tool – send copy if 15 or more with referral**			Yes	No
20	Were agreed protocols followed (circle 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 the nursing care (circle as appropriate)			Yes	No
	Are there any other concerns that impact on the care provision or acceptance of recommended interventions			Yes	No
	If yes, please provide brief explanation				
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)
	•				
	•				
	•				
	•				
				Date	
27	Discussion of outcome/concerns with the patient / family / carers as appropriate			Date	
Name:		Designation		Date	
Name:		Designation		Date	

Resources

NICE National Institute for Health and Care Excellence

Overview | Pressure ulcers: prevention and management | Guidance | NICE

Pressure ulcers: prevention and management

Helping to prevent pressure ulcers | Quick guides to social care topics | Social care | NICE Communities | About | NICE

Jersey Care Commission

Jersey Care Commission | Jersey's Independent Care Regulator

Day Care Standards | Jersey Care Commission

Care Homes Standards | Jersey Care Commission

Home Care Standards | Jersey Care Commission

Healthcare Improvement Scotland

Prevention and management of pressure ulcers standards

Pressure Ulcers | Scottish Patient Safety Programme (SPSP) | ihub - Pressure Ulcers

epuap EUROPEAN PRESSURE ULCER ADVISORY PANEL

EPUAP | European Pressure Ulcer Advisory Panel

National Wound Care Strategy Programme

National Wound Care Strategy Programme | NWCSP

The aSSKINg Framework

PURPOSE-T Registration • CTRU Leeds Research Portal

Wound Care Education for the Health and Care Workforce - elearning for healthcare

Pressure-ulcer-core-curriculum.pdf

The Nursing & Midwifery Council - The Nursing and Midwifery Council

Accountability - The Nursing and Midwifery Council

The Society of Tissue Viability | Formerly known as the TVS

Understanding the association between pressure ulcers and sitting in adults what does it mean for me and my carers? Seating guidelines for people, carers and health & social care professionals - ScienceDirect

'Within 6 Hour' risk assessment – What does this actually mean? - Society of Tissue Viability