Community Social Care Providers Bexley Pressure Ulcer and Safeguarding Process

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- Bexley Safeguarding Adults Board Task and Finish Group

Reader Information

Document Title	Community Social Care Providers Bexley Pressure Ulcer and Safeguarding Process
Type of paper	Protocol
Language	English
Purpose	• Understanding how all multiple category 2, category 3 and category 4 pressure ulcers will be reviewed • To have a consistent approach to identify when the root cause of the pressure ulcer gives rise for a safeguarding enquiry.
Scope of Document	This protocol is: • Applicable to all health and social care staff (including directly employed, contracted, voluntary and agency staff) with all social care provider services within the London Borough of Bexley; • Applicable for all multiple category 2, category 3, and category 4 pressure ulcers.
Authors	• Bexley Safeguarding Adults Board Task and Finish Group
Approval date	28th January 2022
Dissemination and Implementation details	The content of this policy will be disseminated to and implemented by South East London CCG (Bexley)and London Borough of Bexley
Review	JANUARY 2024
Target Audience	London Borough of Bexley Care Homes and Domiciliary Care Providers
Consultation Process	The following interested parties were consulted in the development of this policy: • London Borough of Bexley Safeguarding and Triage Team • SE London CCG (Bexley) Continuing Health Care Team • Bexley Safeguarding Adults Task and Finish Group

Document Control and Amendment Record

Version	Date of Approval		Description of Change
Draft	22.01.22	Task and Finish Group	
Version 1	28.01.22	Task and Finish Group	

Contents Page

Nursing Home Pressure Ulcer and Safeguarding Adult Protocol

Introduction

A pressure ulcer is defined as:

Localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful. (NHSI, 2018).

Typically they occur in a person confined to bed or a chair by an illness and as a result they are sometimes referred to as 'bedsores' or 'pressure sores'.

The term pressure ulcer will be used throughout this policy.

Adult safeguarding is an important feature of the NHS quality agenda, and vital for protecting people in society who might be at risk of abuse of neglect. It is a key responsibility of all care providers and commissioners as a basic right under the Care Act 2014.

Most pressure ulcers are preventable if simple measures are followed and failing to do this could constitute neglect. However, not all pressure ulcers are due to neglect and each individual case should be considered on its own merits. Some pressure ulcers are acquired because a particular individual is prone to them because of their general health, skin fragility or factors relating to end of life. Whilst some are caused by self-neglect.

Bexley Safeguarding Adults Board is committed to providing a co-ordinated approach to the identification of harm to adults.

The Organisation where the pressure ulcer occurred has overall responsibility for the investigation and implementation of subsequent action plans. This includes domiciliary care providers if there are no health involvement at the time the pressure ulcer develops. Organisations should have processes in place to identify incidents that indicate the most significant opportunities for learning and prevention of future harm.

Purpose

The purpose of this protocol is to assist professionals in:

- Understanding how all multiple category 2, category 3 and category 4 pressure ulcers will be reviewed.
- To have a consistent approach to identify when the root cause of the pressure ulcer gives rise for a safeguarding enquiry.
- Enabling staff to determine whether factors giving rise to pressure ulcer formation may indicate a safeguarding concern.

It is important that this protocol dovetails with, and is embedded within, each care home and domiciliary care provider's own pressure ulcer prevention and management policies and guidance.

Scope

This protocol is:

- Applicable to all health and social care staff (including directly employed, contracted, voluntary and agency staff) with all social care provider services within the London Borough of Bexley.
- Applicable for all multiple category 2, category 3, and category 4 pressure ulcers.

Staff should also refer to:

- Pan-London-Updated-August-2016.pdf (londonadass.org.uk)
- Their own policies and procedures on pressure ulcers; and
- Pressure Ulcer | National Wound Care Strategy Programme
- React To Red: Pressure Ulcer Prevention : Training resources
- Pressure ulcers: prevention and management (nice.org.uk)
- Pressure ulcers (nice.org.uk)
- SAR – PUP

Roles and Responsibilities

All agencies and individuals have a role in identifying adults at risk of harm including neglect and taking action to address this.

The six principles of Safeguarding must always be considered when supporting individuals with health and care support needs:

1. Empowerment – people being supported and encouraged to make their own decisions and informed consent.
2. Prevention – It is better to take action before harm occurs.
3. Proportionality – The least intrusive response appropriate to the risk presented.
4. Protection – support and representation for those greatest in need.
5. Partnership – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
6. Accountability – accountability and transparency in safeguarding practice.

All agencies are responsible for ensuring that staff (including directly employed staff, contracted, voluntary and agency staff) can:

- Access this protocol
- Understand their role and responsibilities to preventing harm (where possible)
- Ensure good pressure ulcer prevention is in place
- Attend appropriate training to ensure they can carry out their role.
- Know how to recognise abuse/neglect, raise a concern and should be clear about their role in the safeguarding process.
- Consider the possibility of poor practice and/or neglect as a casual factor of any pressure ulcer.
- Refer all those assessed as having multiple category 2, category 3 or category 4 pressure ulcers to the relevant specialist for advice and support in a timely way.
- Consider whether a safeguarding referral is appropriate.
- All staff must complete the relevant documentation within this protocol and follow their nursing home's procedures e.g., completion of an incident reporting form.

All Social Care Providers should report the pressure ulcer case to London Borough of Bexley (LBB) via screeners@bexley.gov.uk , the CQC and to the GP without delay.

Categories of Pressure Ulcers

Category 1 Pressure Ulcer - Intact skin with non-blanching 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 as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate “at risk” individuals.

Category 2 Pressure Ulcer - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.

Category 3 Pressure Ulcer - 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 Pressure Ulcer - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include 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 (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable Pressure Ulcer: 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 (SDTI): 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 as 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.

NHS Pressure Ulcer categorisation (nationalwoundcarestrategy.net)

Pressure Ulcer Prevention and Management

It is widely accepted that most pressure ulcers are preventable if:

- The circumstances which are likely to result in pressure ulcers are recognised,
- Those at risk are identified early; and
- Appropriate prevention measures are implemented without delay.

On admission/re-admission to social care providers a risk assessment using an appropriate tool must be completed within six hours. The task and finish group recommend that the Waterlow Risk Assessment Tool should be used by social care providers within Bexley. The results of this risk assessment must be documented in the individuals care record and any associated care plans documented accordingly.

It is expected that management of and prevention and care of pressure ulcers includes:

- Any identified care need should be met and clearly documented.
- Risk assessment should be on-going and is the responsibility of the registered nursing home professionals working with that person.

Pressure Ulcers and Neglect

Pressure ulcers can sometimes occur because of neglect and /or omission of care whether this is deliberate or unintended.

Pressure ulcers could also be acquired by people in their own home, possibly due to self-neglect or the individual themselves refusing help and advice. However, consideration must always be given as to whether neglect by others has occurred. When present, pressure ulcers require monitoring and appropriate treatment to prevent unnecessary pain and suffering for the person concerned.

It is important to note that harm does not need to be deliberate. It is not the intent that needs to be considered but the harm (developing a pressure ulcer) that has resulted from the act or omission and which should trigger safeguarding adult procedures. Self-neglect can in certain circumstances also be a safeguarding issue and should be reported as such unless the person has the capacity to refuse consent for treatment and / or for the concern to be raised.

Standards of Practice when Category 3 or 4 Pressure Ulcer is developed

Within Bexley the Tissue Viability Nurse can provide advice and support to care home residents, carers and healthcare professionals. Criteria for this service is at Appendix M. Referral form is at Appendix N.

When multiple category 2 pressure ulcers, category 3 or category 4 pressure ulcers are identified staff must complete the following actions depending on where pressure ulcer originated:

Care Homes:

- Appendix A – Care Home with Nursing
- Appendix B – Care Home (residential) with no District Nurse input
- Appendix C – Care Home (residential) with District Nursing
- Appendix D – Admitted to care home with pressure ulcer

Domiciliary Care:

- Appendix E – Domiciliary Care with no District Nurse input
- Appendix F – Domiciliary Care with District Nurse input
- Appendix G – Admitted to Domiciliary Care case load with pressure ulcer

No formal care:

- Appendix H – No formal care

Once the correct process has been identified and the LBB (via screeners@bexley.gov.uk) has been notified the local authority will send the Investigation Tool to the provider for completion:

- The Pressure Ulcer Investigation Tool (Appendix I) will be sent to the care home for completion or The Pressure Ulcer Investigation Tool (Appendix J) will be sent out to domiciliary care providers
- Responsibility for completing this tool lies with the organisation responsible for the person's care in the care home or domiciliary care provider where the pressure damage developed.
- Support or guidance can be obtained from the CCG Safeguarding Adult Lead; (**bexccg.safeguardingadult@nhs.net**) and the Investigation Tool must be completed and returned within **10 working days** to **bexccg.safeguardingadult@nhs.net**;
- A virtual Pressure Ulcer Panel Group meeting will be convened by the Designate Nurse for Adult Safeguarding of the CCG where the organisation responsible for the RCA can present its findings to the panel for a decision whether the pressure ulcer was as a result of neglect or an omission of care
- The CCG will advise the care provider and LBB of the outcome.
- The provider organisation retains the responsibility for advising CQC of the outcome and the implementation of the action plan.
- If the outcome is identified as not being as a result of neglect or omission of care then a safeguarding enquiry (section 42) will not be completed and the concern closed.
- If the outcome identified that the pressure ulcer developed as a result of neglect and/or omission of care then a section 42 safeguarding enquiry will be commenced by the local authority.

Training

Training on the implementation of this protocol will be available through the Provider Forums and developed by the Bexley Safeguarding Adults Board - Bexley Safeguarding Adults Board (safeguardingadultsinbexley.com) (BSAB). Training on the provision of Pressure Ulcer care and management is the responsibility of each care provider

Review and monitoring of the protocol

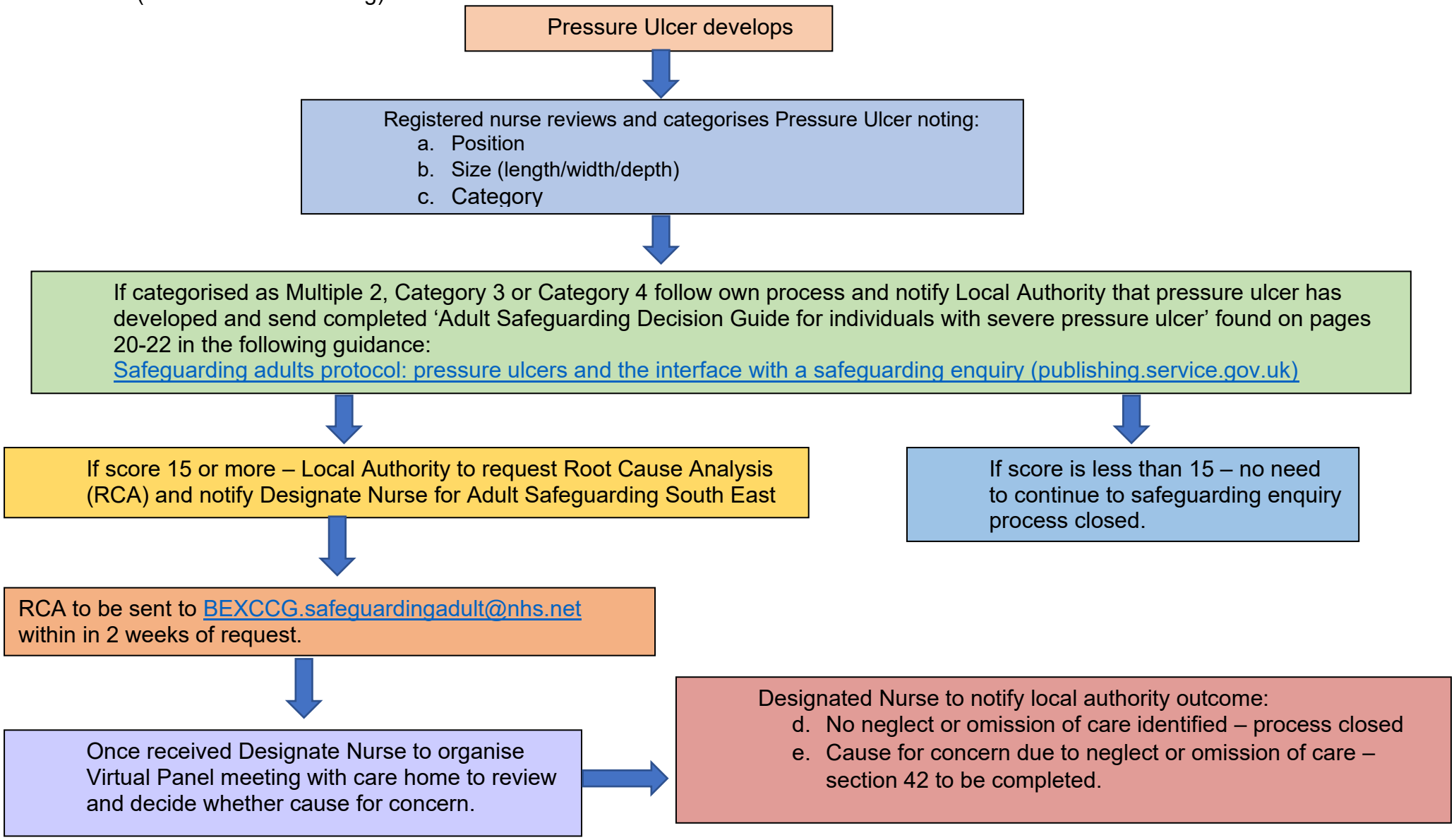
There will be an annual review of the protocol which will be undertaken by the CCG Designate Nurse for Adult Safeguarding and the LBB Head of Safeguarding Adults The findings of the review and any suggestions for improvement will be taken to the BSAB for discussion and ratification.

Appendix A

Process for Pressure Ulcer – Care Home (with nursing)

1. Pressure Ulcer develops in Care Home (nursing)
2. Registered nurse reviews and categorises Pressure Ulcer noting:
    a. Position
    b. Size (length/width/depth)
    c. Category
3. If categorised as Multiple 2, Category 3 or Category 4 follow own process and notify Local Authority that pressure ulcer has developed and send completed 'Adult Safeguarding Decision Guide for individuals with severe pressure ulcer' found on pages 20-22 in the following guidance: Safeguarding adults protocol: pressure ulcers and the interface with a safeguarding enquiry (publishing.service.gov.uk)
4. If score is less than 15 – no need to continue to safeguarding enquiry – process closed
5. If score 15 or more – Local Authority to request Root Cause Analysis (RCA) and notify Designate Nurse for Adult Safeguarding South East London CCG (Bexley).
6. RCA to be sent to BEXCCG.safeguardingadult@nhs.net within in 2 weeks of request.
7. Once received Designate Nurse to organise Virtual Panel meeting with care home to review and decide whether cause for concern.
8. Designate Nurse to notify local authority outcome:
    a. No neglect or omission of care identified – process closed
    b. Cause for concern due to neglect or omission of care – section 42 to be completed.

Flow chart A (care home with nursing)



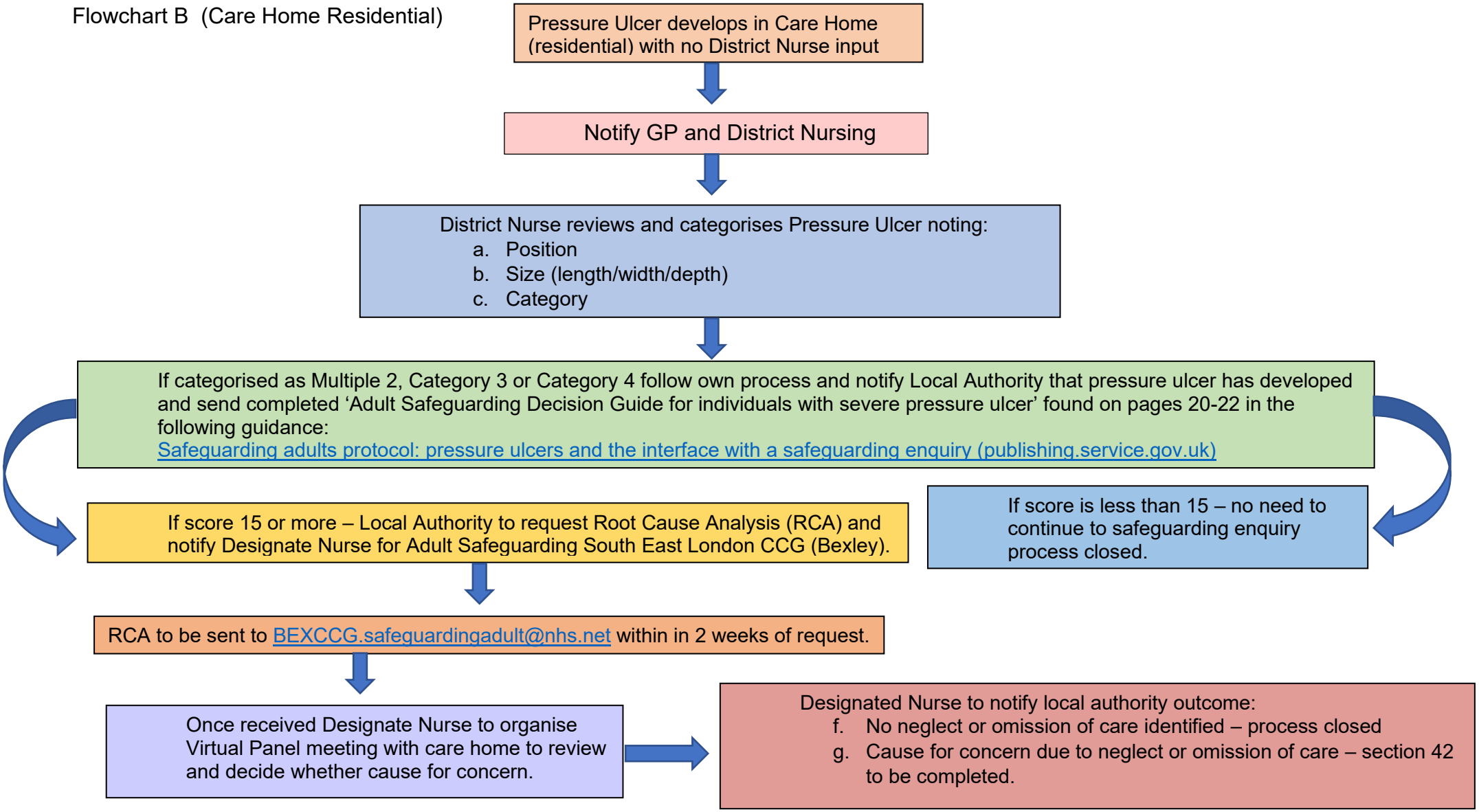
Appendix B

Process for Pressure Ulcer – Care Home (Residential)

1. Pressure Ulcer develops in Care Home (residential) with no District Nurse input
2. Notify GP and District Nursing
3. District Nurse reviews and categorises Pressure Ulcer noting:
    a. Position
    b. Size (length/width/depth)
    c. Category
4. If categorised as Multiple 2, Category 3 or Category 4 care home to follow own process and notify Local Authority that pressure ulcer has developed and send completed 'Adult Safeguarding Decision Guide for individuals with severe pressure ulcer' found on pages 20-22 in the following guidance: Safeguarding adults protocol: pressure ulcers and the interface with a safeguarding enquiry (publishing.service.gov.uk)

5. If score is less than 15 – no need to continue to safeguarding enquiry – process closed
6. If score 15 or more – Local Authority to request Root Cause Analysis (RCA) and notify Designate Nurse for Adult Safeguarding South East London CCG (Bexley).
7. RCA to be sent to BEXCCG.safeguardingadult@nhs.net within in 2 weeks of request.
8. Once received Designate Nurse to organise Virtual Panel meeting with care home to review and decide whether cause for concern.
9. Designate Nurse to notify local authority outcome:
    a. No neglect or omission of care identified – process closed
    b. Cause for concern due to neglect or omission of care – section 42 to be completed.

Flowchart B (Care Home Residential)

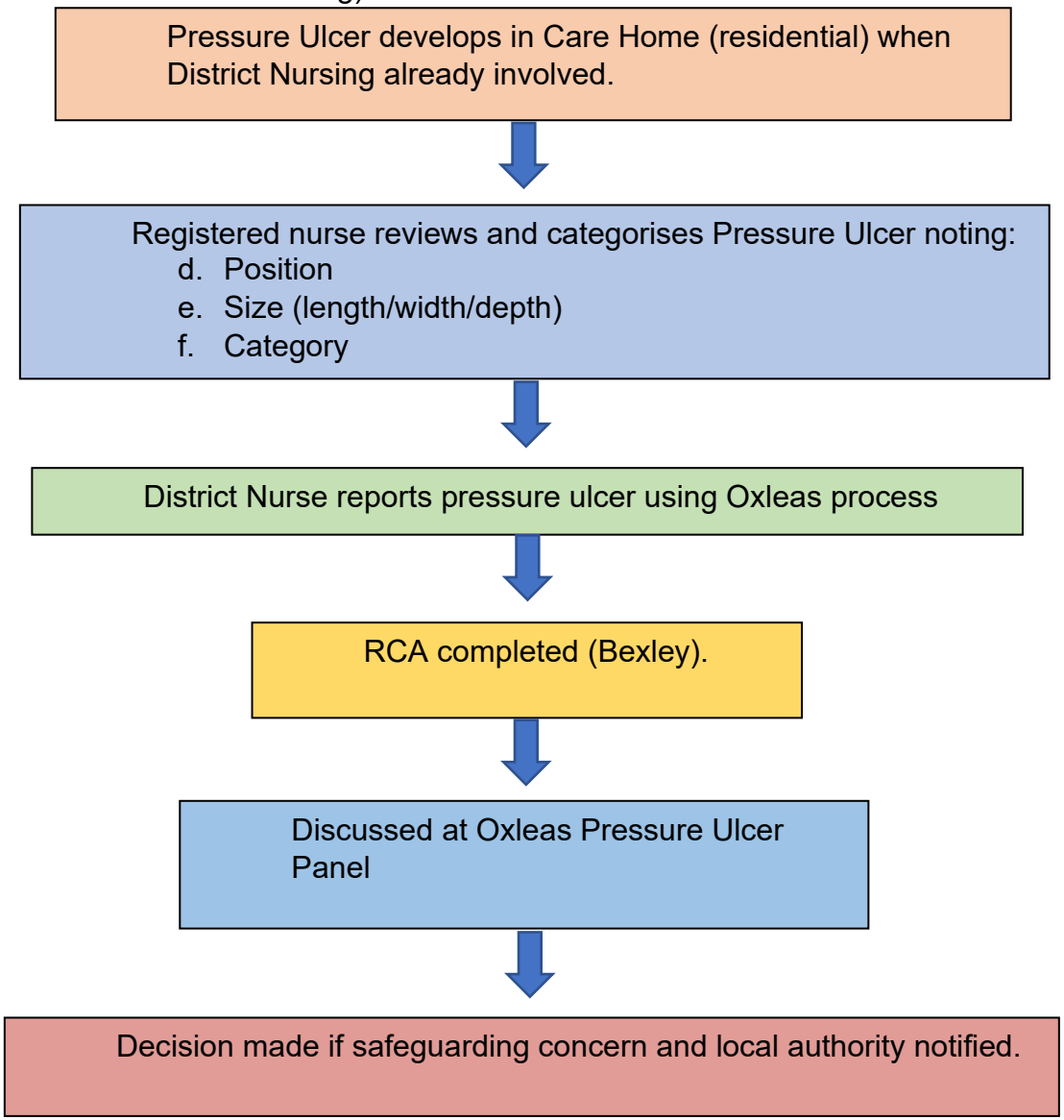


Appendix C

Process for Pressure Ulcer – Care Home (Residential) Known to District Nursing

1. Pressure Ulcer develops in Care Home (residential) when District Nursing already involved
2. District Nurse reviews and categorises Pressure Ulcer noting:
    a. Position
    b. Size (length/width/depth)
    c. Category
3. District Nurse reports pressure ulcer using Oxleas process
4. Pressure Ulcer Investigation Tool completed
5. Discussed at Oxleas Pressure Ulcer Panel
6. Decision made if safeguarding concern and local authority notified.

Flowchart C (Care Home with District Nursing)

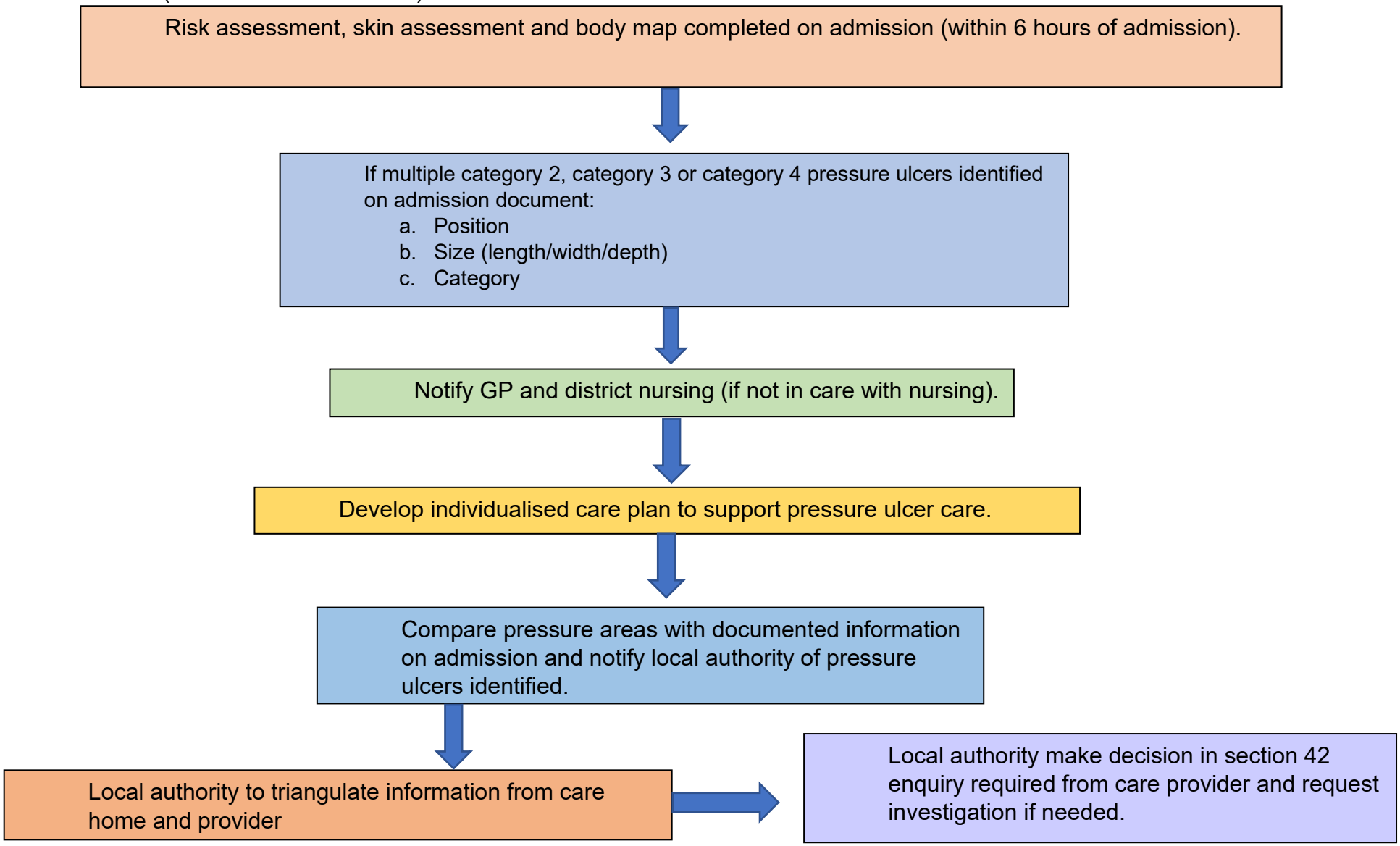


Appendix D

Process for Pressure Ulcer Identified on Admission to Care Home

1. Risk assessment, skin assessment and body map completed on admission (within 6 hours of admission).
2. If multiple category 2, category 3 or category 4 pressure ulcers identified on admission document:
    a. Position
    b. Size (length/width/depth)
    c. Category
3. Notify GP and district nursing (if not in care with nursing).
4. Develop individualised care plan to support pressure ulcer care
5. Compare pressure areas with documented information on admission and notify local authority of pressure ulcers identified.
6. Local authority to triangulate information from care home and provider
7. Local authority make decision in section 42 enquiry required from care provider and request investigation if needed.

Flowchart D (admission to care home)



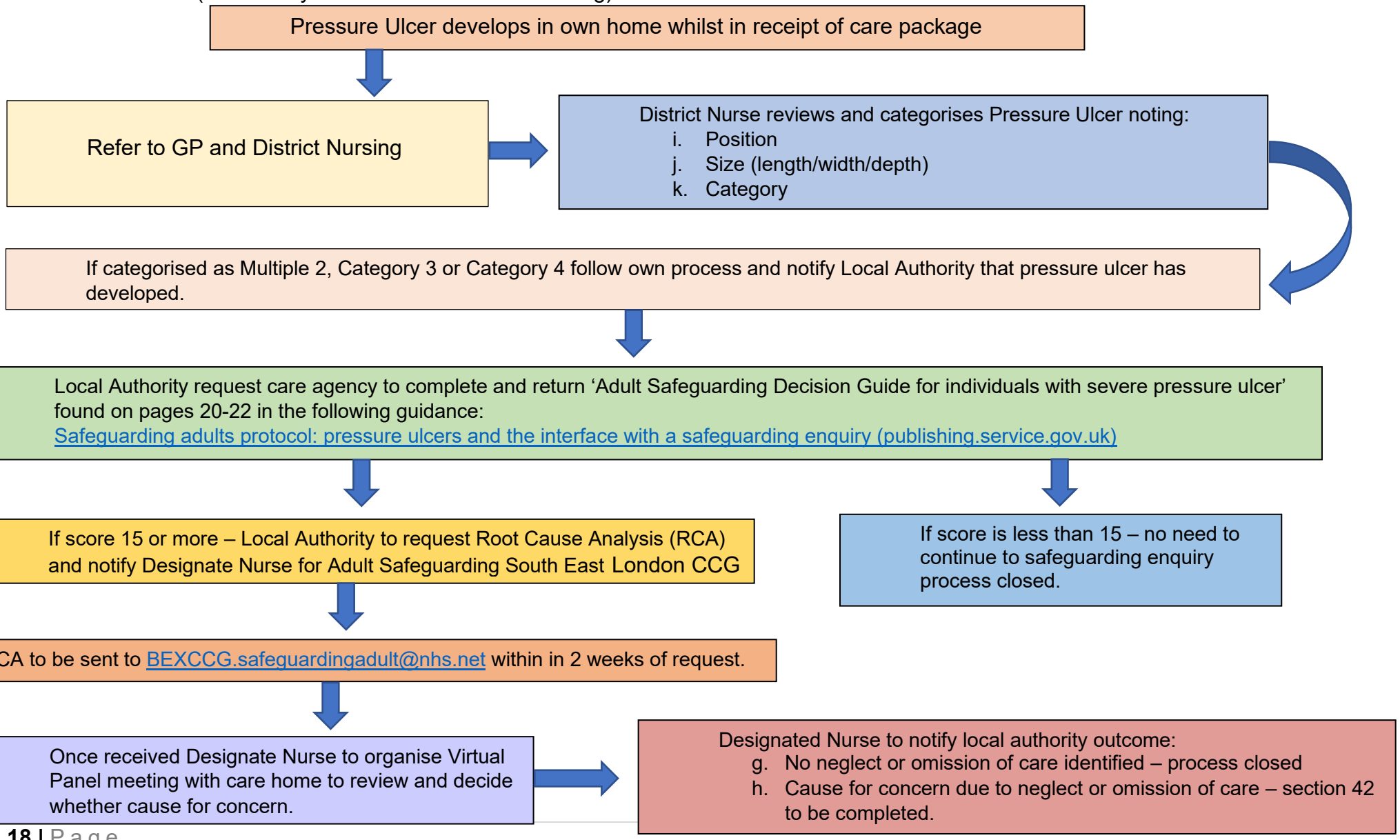
Appendix E

Process for Pressure Ulcer – Domiciliary Care (No District Nursing)

1. Pressure Ulcer develops in own home whilst in receipt of care package
2. Refer to GP and District Nursing
3. District Nurse reviews and categorises Pressure Ulcer noting:
    a. Position
    b. Size (length/width/depth)
    c. Category
4. If categorised as Multiple 2, Category 3 or Category 4 follow own process and notify Local Authority that pressure ulcer has developed.
5. Local Authority request care agency to complete and return 'Adult Safeguarding Decision Guide for individuals with severe pressure ulcer' found on pages 20-22 in the following guidance:
   Safeguarding adults protocol: pressure ulcers and the interface with a safeguarding enquiry (publishing.service.gov.uk)

6. If score is less than 15 – no need to continue to safeguarding enquiry – process closed
7. If score 15 or more – Local Authority to request Root Cause Analysis (RCA) and notify Designate Nurse for Adult Safeguarding South East London CCG (Bexley).
8. RCA to be sent to BEXCCG.safeguardingadult@nhs.net within in 2 weeks of request.
9. Once received Designate Nurse to organise Virtual Panel meeting with care home to review and decide whether cause for concern.
10. Designate Nurse to notify local authority outcome:
    a. No neglect or omission of care identified – process closed
    b. Cause for concern due to neglect or omission of care – section 42 to be completed.

Flowchart E (Domiciliary Care with NO District Nursing)

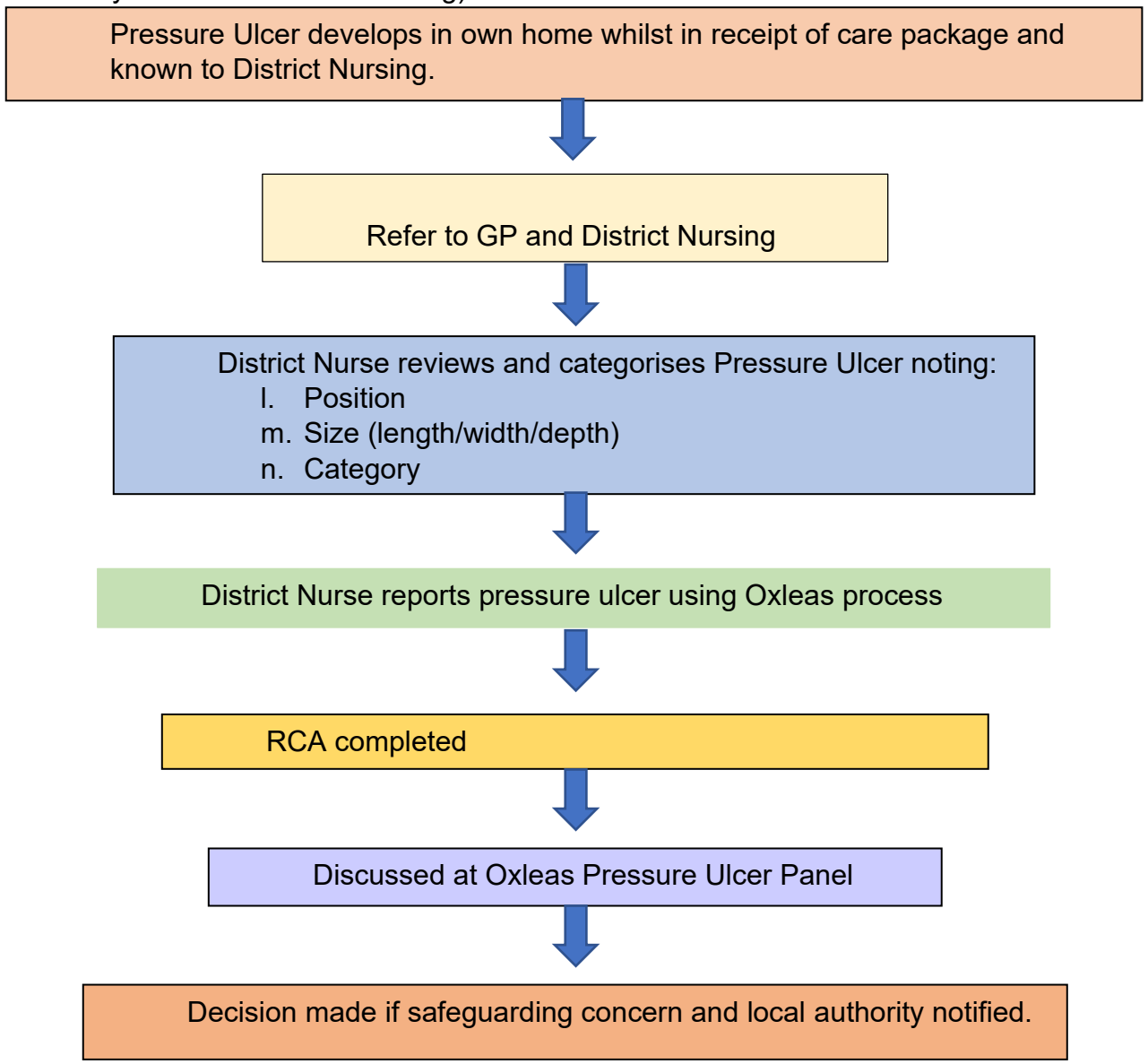


Appendix F

Process for Pressure Ulcer – Domiciliary Care (known to District Nursing)

1. Pressure Ulcer develops in own home whilst in receipt of care package and known to District Nursing
2. Refer to GP and District Nursing
3. District Nurse reviews and categorises Pressure Ulcer noting:
    a. Position
    b. Size (length/width/depth)
    c. Category
4. District Nurse reports pressure ulcer using Oxleas process
5. Pressure Ulcer Investigation Tool completed
6. Discussed at Oxleas Pressure Ulcer Panel
7. Decision made if safeguarding concern and local authority notified.

flowchart F (Domiciliary Care with District Nursing)

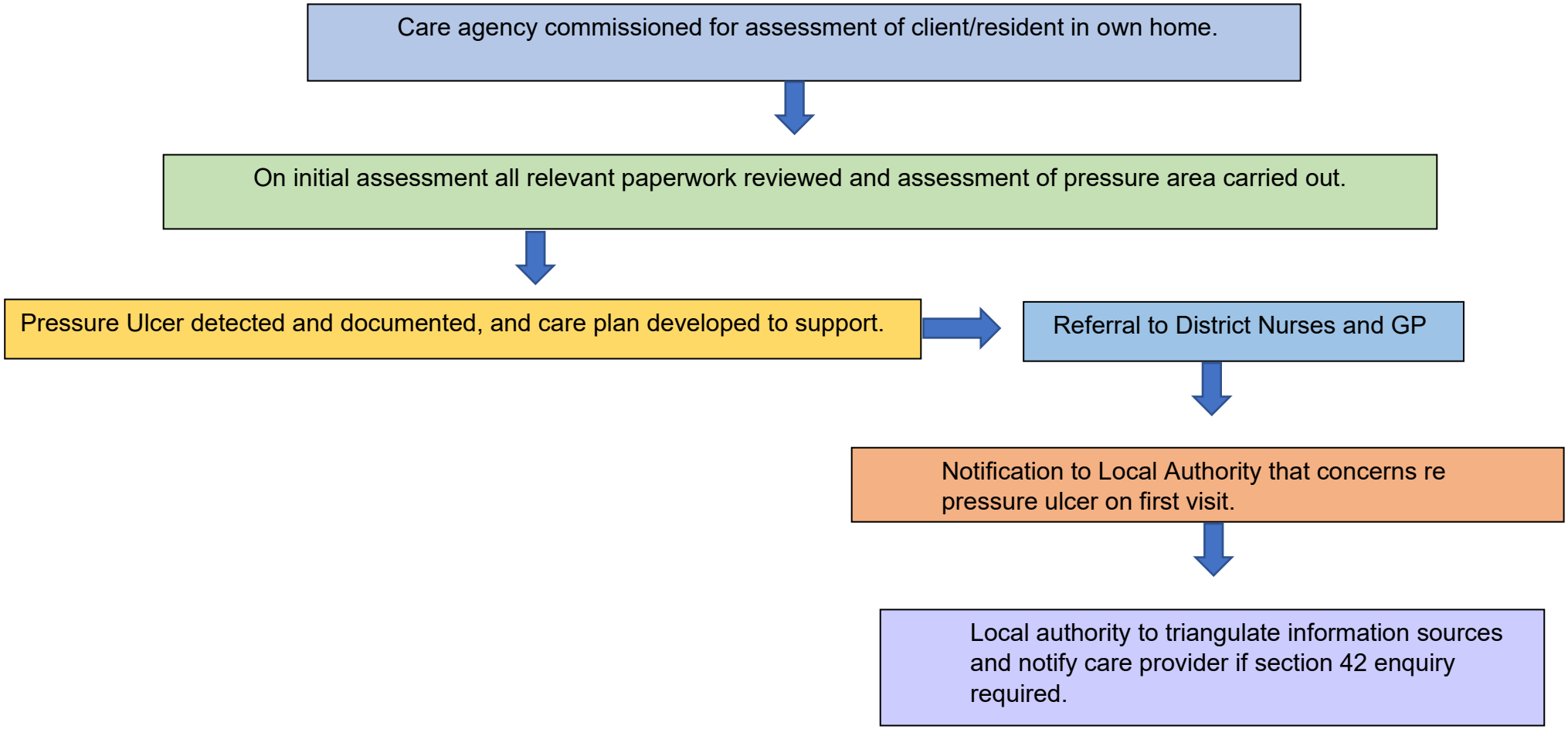


Appendix G

Process for Pressure Ulcer Identified on first visit from Domiciliary Care Provider

1. Care agency commissioned for assessment of client/resident in own home
2. On initial assessment all relevant paperwork reviewed and assessment of pressure area carried out.
3. Pressure Ulcer detected and documented, and care plan developed to support.
4. Referral to District Nurses and GP
5. Notification to Local Authority that concerns re pressure ulcer on first visit
6. Local authority to triangulate information sources and notify care provider if section 42 enquiry required.

Flowchart G (Domiciliary Care on admission to case load)

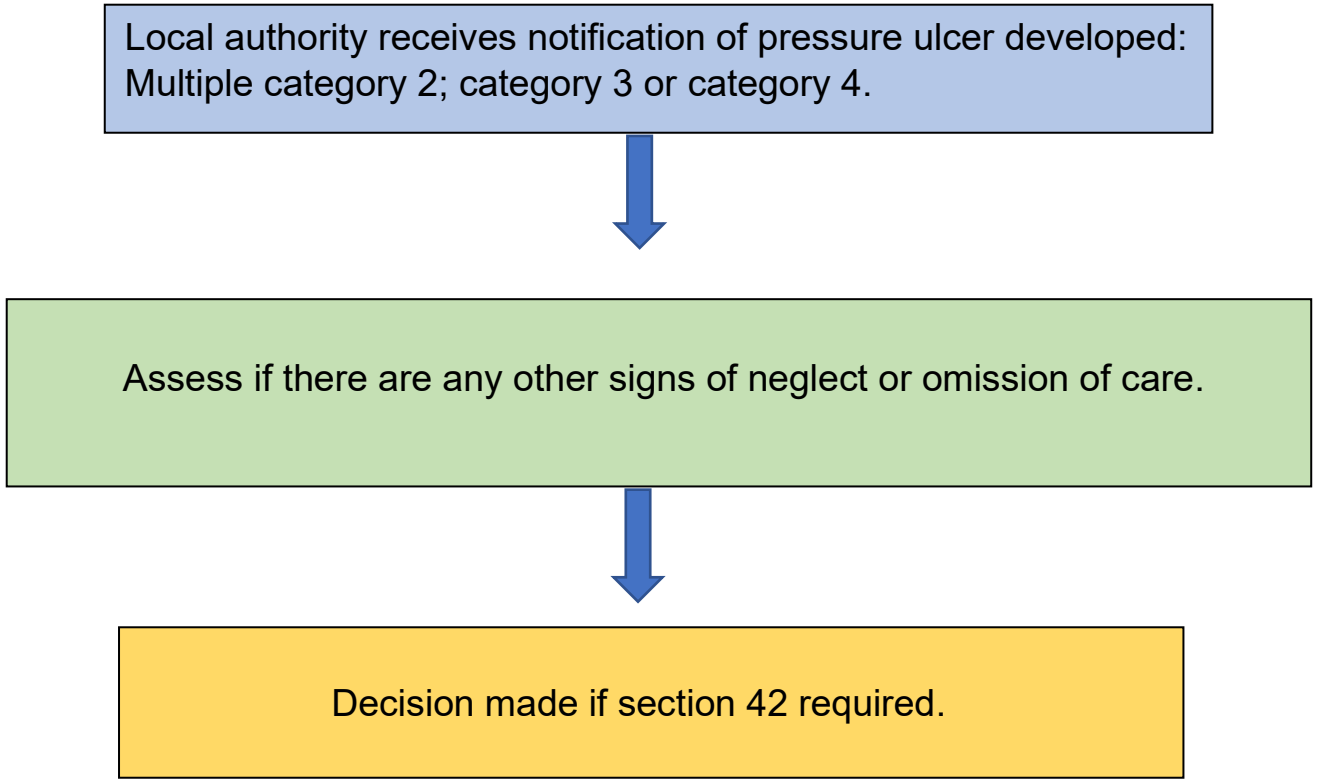


Appendix H

Process for Pressure Ulcer – No formal care

1. Local authority receives notification of pressure ulcer developed: Multiple category 2; category 3 or category 4
2. Assess if there are any other signs of neglect or omission of care
3. Decision made if section 42 required

Flowchart H (No formal Care)



Appendix I

Bexley Safeguarding Adults Board Pressure Investigation Tool

Service:	Resident:
Completed By	Date Completed:

Pressure Ulcer Details

Pressure Ulcer Site	Pressure Ulcer Size	Category	Date identified
1			
2			
3			
4			

Risks and Predisposing Factors

	Yes	No
Poor Mobility/Bed Bound		
End of Life		
Stroke		
Cardiovascular Disease		
Peripheral Vascular Disease		
Neurological Disease		
Multi-Organ Failure		
Diabetes		
Poor nutrition		
Incontinence		
Heart Failure		
Anaemia		
Other (Please List)		
Past Medical History		

Compliance with Policies

	Yes	No
1. Was the resident known to have a history of pressure ulcers on admission to care home or whilst within the care home? a) If so what category was it? i. Site ii. Date		

iii. Size iv. Origin of pressure ulcer		
2. a) Was the resident given a visual skin assessment of all high risk areas within 6 hours of admission to care home? And b) Was the resident given a visual skin assessment of all high risk areas routinely?		
3. a) Was a water-low score carried out within 6 hours of admission to care home? And B)Was a water-low score carried out routinely?	Score on admission Score now	
4. Was there pressure relieving / redistribution equipment in use? a) If yes what equipment was in place? b) When was the last review completed?		
5. Was pressure area prevention care documented on personal care plan?		
6. Has the selection chart of equipment been followed when reviewing the resident's skin integrity?		
7. If the resident suffers with incontinence has a continence assessment been completed?		
8. Has appropriate barrier products been supplied to the resident? a) If Yes – what was used		
9. Can compliance with the following policies and guidelines be demonstrated in this case? a) Pressure \ulcer Prevention Policy b) Infection Control Policy c) Nutritional Screening i. Has this been acted on (if needed)		
10. Has an incident form been completed?		
11. Was there evidence of communication with staff during handovers regarding pressure ulcer?		
12. Does the documentation support that the resident was given all the information needed to make an informed decision? a) Were they able to understand it b) If no was this as a result of lack of mental capacity? c) If yes was a mental capacity Assessment completed for pressure ulcer care d) If yes please send with this RCA		
13. Have the multidisciplinary team been involved with the care of this resident due to pressure ulcer? If yes who? (Add dates of assessment) a) GP		

b) TVN c) District Nursing d) Dietician e) Podiatry f) Continence g) Family		
14. Are the resident's relatives aware that the patient has a pressure ulcer? (If resident consents) Has this been documented?		

Incident Summary

Description Summary of care of 2 weeks prior to identification of this pressure ulcer Actions taken

Root Cause

Good practice points
Lessons learnt.
Recommendations

Action Plan

Recommendation	Action	Lead	Outcome measure	Date completed

Appendix J

Pressure Ulcer developed with Domiciliary Care in place (not Oxleas)

		Yes	No
1	Was a risk assessment completed when patient admitted to caseload		
2	Was a repeat risk assessment completed if patient condition deteriorated		
3	Was there a care plan for risk of pressure ulcers		
4	Were all visits completed		
5	Was care delivered as per care plan		
6	What date did pressure areas deteriorate		
7	What action was taken by care staff to raise concern re deterioration of pressure areas		
8	When was this action taken		

Appendix K

Oxleas Pressure Ulcer Reporting Flow Chart

Complete Waterlow score and pressure ulcer risk assessment for every new referral within 6

Patient is not currently at risk
Re-assess if condition alters.
Patients with devices such as catheters should be regularly checked for DRPD

Patient identified as 'at risk' or as at 'high risk' of developing a pressure ulcer
(see NICE definition 2015)

Complete pressure ulcer prevention care plan and put in place appropriate pressure relieving strategies as per NICE guidelines/ Oxleas Policy

Conduct/document both SSKIN assessment and Waterlow score at least monthly or as frequently as condition alters

Select appropriate pressure relieving equipment as per Bexley or Greenwich guidelines and upgrade/downgrade as condition alters

Monitor skin condition/ pressure areas at every assessment/ visit, using SSKIN mnemonic to document RIO progress notes

Provide patient/ carer with pressure ulcer information leaflet (PUPS)

Patient has a Category2, 3 & 4 pressure ulcer/s, unstageable ulcers, deep tissue injury (DTI), moisture associated skin damage (MASD) and device related pressure ulcers (DRPD) – this includes deterioration of pressure ulcers

Treatment Plan

- The clinician visiting the patient MUST notify team lead or nurse in charge on the same day that the pressure ulcer is found
- Follow pressure ulcer prevention care plan and ensure SSKIN is documented in the progress notes
- Document updated Waterlow and MUST assessment scores
- Check that all pressure relieving equipment is in good working order
- With patient consent, photograph wound then upload into patient's RIO records
- Send to TVN link nurse/podiatrist for confirmation of pressure ulcer category
- Refer to local safeguarding team using RiO form

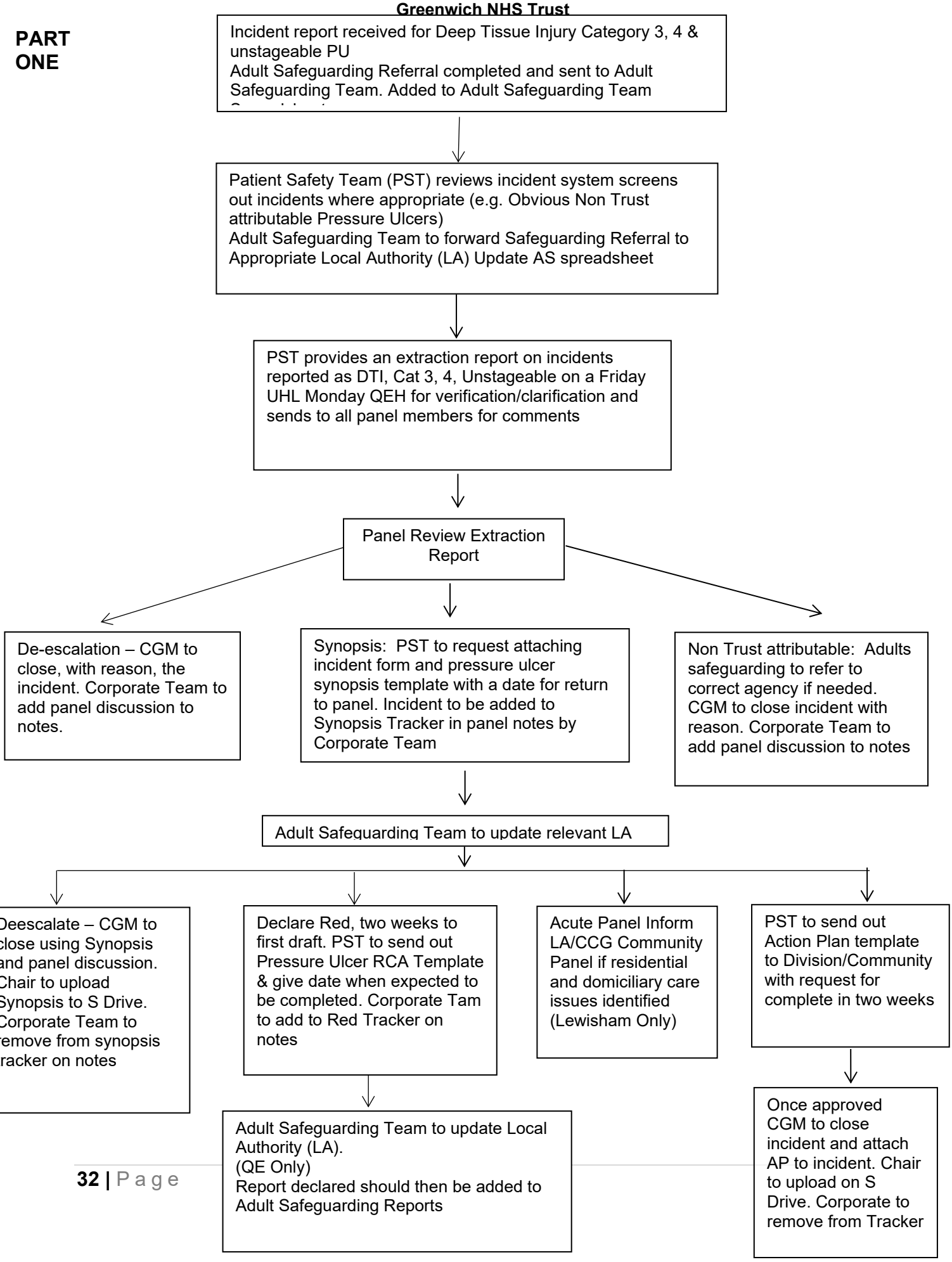
Reporting

- Complete a Datix for all category 2, 3, 4 and unstageable ulcers, deep tissue injury (DTI), moisture associated skin damage (MASD) and medical device related pressure ulcers
- Identify where pressure ulcer originated and or deteriorated
- A duty of candour (DOC) letter should be sent for category 3 and above pressure ulcers acquired in our care
- **ALL reportable incidents of pressure ulcers Category 3 and above will require the completion of a Pressure Ulcer Investigation Tool (PUIT) as per the Pressure Ulcer Policy)**
- The PUIT must be completed within 14 days of the incident being reported
- Each PUIT will be reviewed by the TVN link nurse and the team lead and if the case is found to be clearly unavoidable, then this will be closed in Datix by the handler and documents uploaded to Datix and RiO
- If the case has been reviewed by the TVN lead has learning or is found to be 'Avoidable' by the TVN link this will be required to be presented at the monthly pressure ulcer panel
- If a pressure ulcer deteriorates further, a **new Datix, new DOC letter** and **new PUIT** must be completed

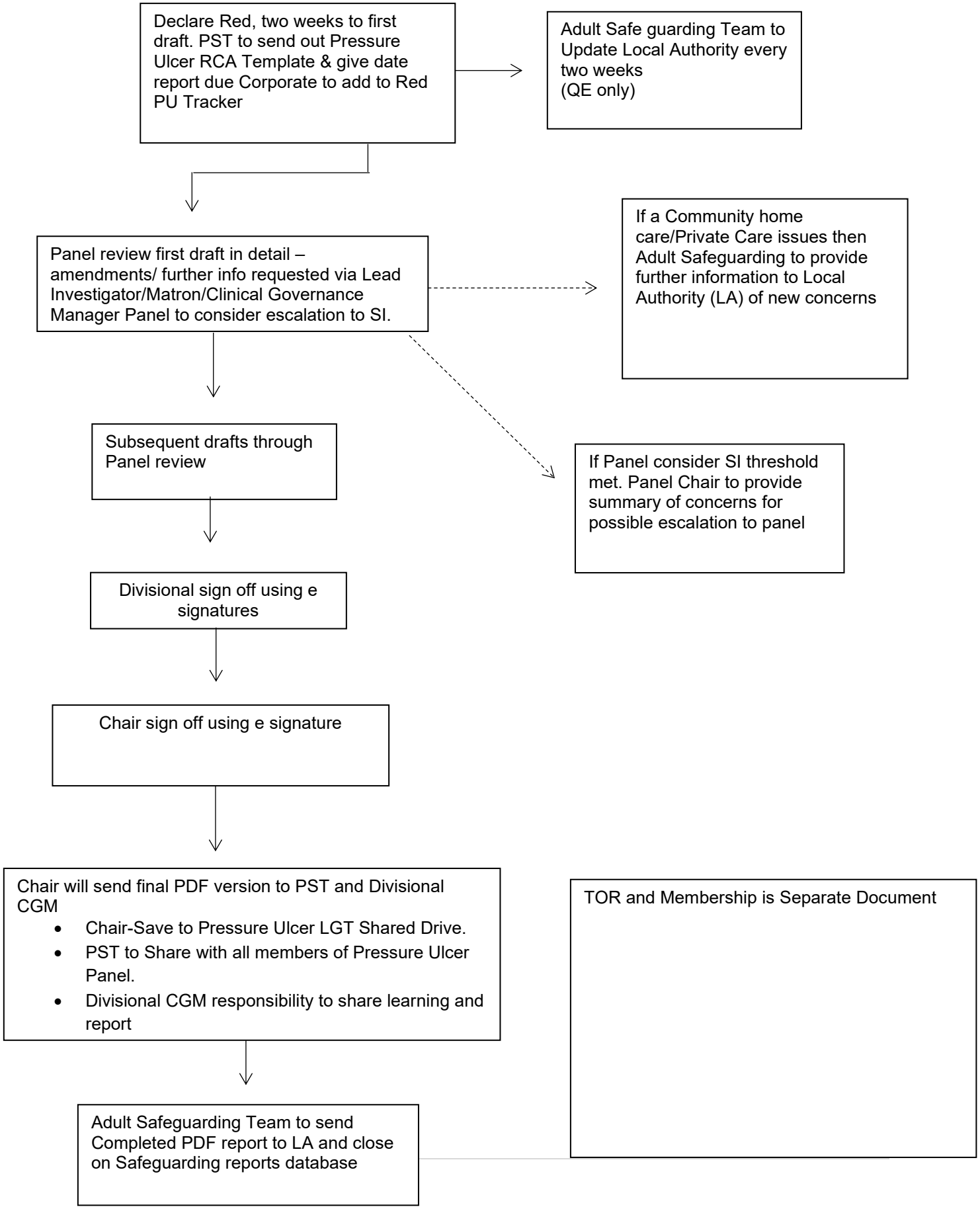
Appendix L

PART ONE

Pressure Ulcer Panel Process (2020) Lewisham and Greenwich NHS Trust



PART TWO


Declare Red, two weeks to first draft. PST to send out Pressure Ulcer RCA Template & give date report due Corporate to add to Red PU Tracker
Adult Safe guarding Team to Update Local Authority every two weeks (QE only)
Panel review first draft in detail – amendments/ further info requested via Lead Investigator/Matron/Clinical Governance Manager Panel to consider escalation to SI.
If a Community home care/Private Care issues then Adult Safeguarding to provide further information to Local Authority (LA) of new concerns
Subsequent drafts through Panel review
If Panel consider SI threshold met. Panel Chair to provide summary of concerns for possible escalation to panel
Divisional sign off using e signatures
Chair sign off using e signature
Chair will send final PDF version to PST and Divisional CGM
Chair-Save to Pressure Ulcer LGT Shared Drive.
PST to Share with all members of Pressure Ulcer Panel.
Divisional CGM responsibility to share learning and report
TOR and Membership is Separate Document
Adult Safeguarding Team to send Completed PDF report to LA and close on Safeguarding reports database

Appendix M

BEXLEY CARE

We're here for you

TISSUE VIABILITY REFERRAL FORM FOR PATIENTS WITH A BEXLEY GP

PATIENT'S NAME:
ADDRESS:

POSTCODE
TELEPHONE:

NHS NO:
D.O.B
GENDER: Male / Female
Ethnicity:
GP:

Please email oxl-tr.complexwoundcare@nhs.net

TYPE OF WOUND/UNDERLYING CAUSE(e.g. pressure injury, leg ulcer, post op, traumatic, burn, malignancy)	**DURATION OF WOUND:**
SITE/S OF WOUND:	**SIZE/DEPTH OF WOUND: (E.P.U.A.P pressure ulcer classification/category)** **EUPA grade:** **Waterlow Score=**
CLINCIAL APPEARANCE OF WOUND BED:	**CONDTION OF SURROUNDING SKIN:(e.g. erythema, cellulites, oedema, eczema, maceration, allergy)**
COMPROMISING PATHOLOGY(e.g. co-morbidities, poor nutrition/hydration, diabetes, immobility)	**CURRENT TREATMENT(e.g. dressing products, pressure relieving equipment)**
ABPI/TEST RESULTS:	**OTHER PROFESSIONAL/S INVOLVED IN CARE:**
REASON FOR REFERRAL/PRIORITY:(brief description)	**Referrer Name:** **Position/Base**
DATE OF REFERRAL:	**REQUEST FOR: *please tick*** **TELEPHONE ADVICE:** **JOINT VISIT:** **CLINIC APPIONTMENT:**

Please note incomplete forms may result in a possible delay in your patient being seen.

Appendix N

Criteria for Referral to the Complex Wound Care Team.

The team accept referrals for the following conditions.

Tissue Viability Service:

- Complex wounds which fail to heal / deteriorate despite appropriate management for 4 weeks
- Clinically infected wounds not responding to appropriate treatment
- Complex leg ulcers
- Healed leg ulcer advice
- Wounds which require conservative sharp debridement
- Wounds which require Topical Negative Pressure therapy
- Specialist treatment options
- Grade 3 and above pressure ulcers
- Pressure ulcer prevention advice
- Current/ recurrent cellulitis of the lower limb

Exclusion criteria:

- Patients who do not fall under the care of Adult services
- Patients that do not have a wound or skin condition