

Protocol for Determining Neglect in the Development of a Pressure Ulcer

Issues to Support Decision

Review information already gathered about the patient then consider the pressure ulcer history. Any grade 3 ulcer (EPUAP - European Pressure Ulcer Advisory Panel Scale) should be considered as possible neglect.

Neglect is described in the Bradford District Adult Protection and Procedures Appendix 3 – Indicators of neglect.

“Persons physical condition/appearance is poor e.g. ulcers, pressure ulcers, soiled or wet clothing”.

If a patient presents with pressure ulcers which are assessed as grade 3 or 4 on the EPUAP Scale, the following assessment should be done by a qualified nurse and the decision reviewed by a second clinical trained person.

Use the following criteria to assess the patient and the history of the development of the pressure ulcer.

To compile the report use the attached format. Review the standard and detail of documentation and evidence of care regime.

Consider the evidence against the following criteria:

The Patient History

- Whether rapid onset and deterioration to a severe ulcer
- Patient Compliance/Behaviour
- Whether extensive damage in a low risk patient

Co-morbidity

- Medical history
- Chronic disease
- Palliative Care
- Mental Health issues

Care Regime

- Poor quality care: standard of assessment and use of relevant policy and procedures to support care and appropriate documentation with a plan of care.
- Whether appropriate equipment has been provided
- Evidence implementation of plan of care
- Continence management: hygiene
- Deterioration of appearance
- General indicators of care – e.g. clean nails, oral care
- Inappropriate prevention and treatment regimes
- Recurrent pressure ulcers
- Evidence of risk management

Hydration and Nutrition

- Evidence of intake monitoring
- Fluid balance
- Regular weighing

Under/over use of medication

- Note use of sedation if patient is immobile for extended periods
- Is pain assessed and managed

Contributory Circumstances of Pressure Ulcers

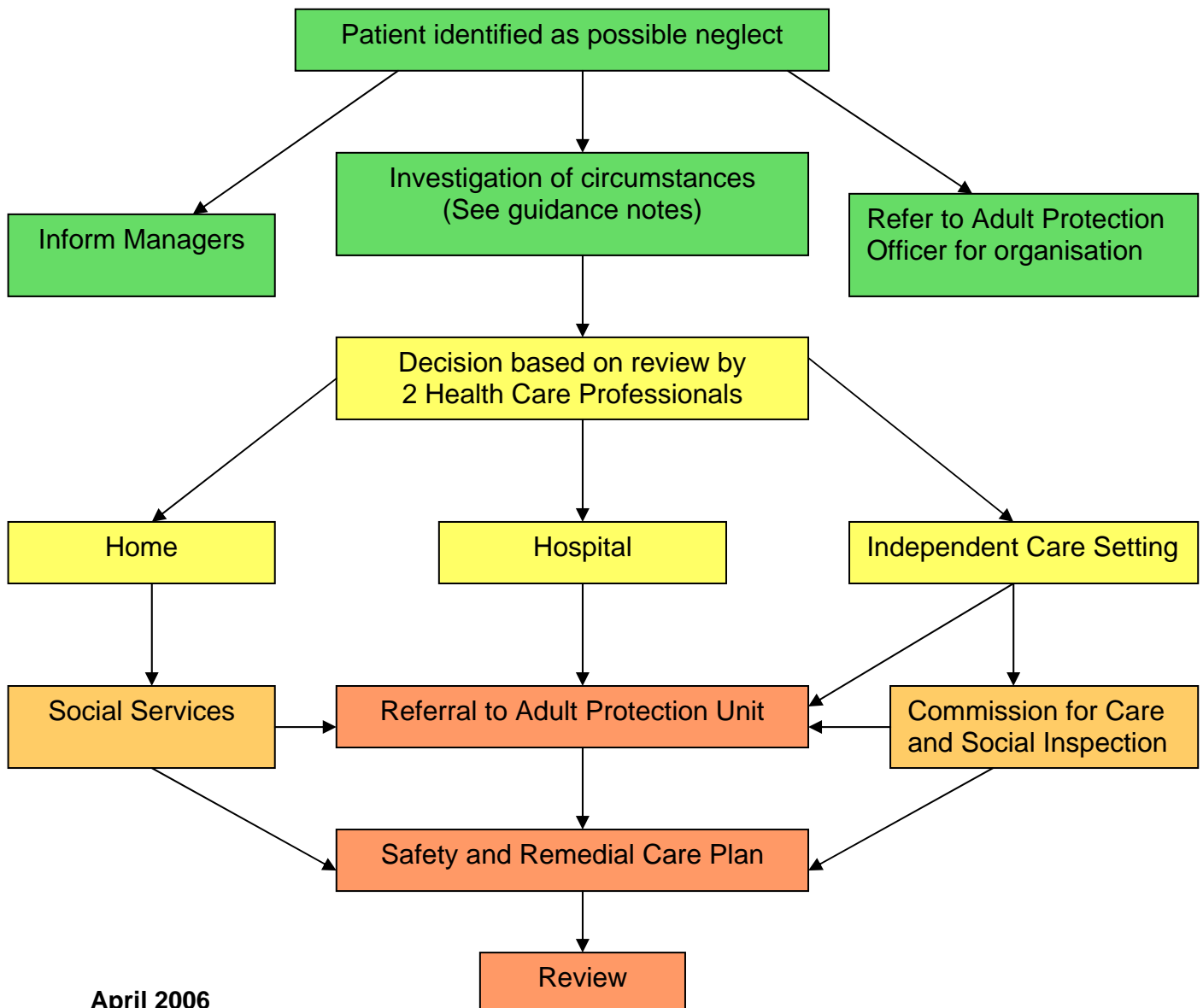
- Detailed history of patient journey - e.g. environmental changes
- Change (s) in care setting (s)
- History of falls
- Previous history of pressure ulcers
- Carer involvement
- Health and Social Care involvement

The information should be documented in the recommended format of a report (see attached template), and the case reviewed by a second clinical person to support the decision.

Where appropriate photographic evidence to support the report may be useful. If photographs are taken consent should be documented using the information in the Photography and Video Recording of Patients Policy. However, if there are clear issues of neglect which may lead to a criminal investigation the photography should be done regardless of consent, as described in Bradford District Adult Protection Procedures.

For Guidance on the Prevention and Treatment of Pressure Ulcers Refer to the National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 29 or Organisational Pressure Ulcer Policies.

PROCESS



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