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Investigating staff knowledge of safeguarding and pressure ulcers in care homes

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Abstract

Objective: To investigate whether nursing/care home staff regard pressure ulceration as a safeguarding issue; and to explore reporting mechanisms for pressure ulcers in nursing/care homes.

Methods: Sixty five staff members from 50 homes within one clinical commissioning group completed a questionnaire assessing their experiences of avoidable and unavoidable pressure ulcers, grading systems, and systems in place for referral to safeguarding teams. Understanding of safeguarding was assessed in depth by interviews with 11 staff members.

Results: Staff observed an average of 2.72 pressure ulcers in their workplaces over the last 12 months; judging 45.6% to be avoidable. Only a minority of respondents reported knowledge of a grading system (mostly the EPUAP/NPUAP system). Most respondents would refer pressure ulcers to the safeguarding team: the existence of a grading system, or guidance, appeared to increase that likelihood. Safeguarding was considered a priority in most homes; interviewees were familiar with the term *safeguarding*, but some confusion over its meaning was apparent. Quality of written documentation and verbal communication received prior to residents returning from hospital was highlighted. However, respondents expressed concern over lack of information regarding skin integrity. Most staff had received education regarding ulcer prevention or wound management during training, but none reported post-registration training or formal education programmes; with reliance placed on advice of district nurses or tissue viability specialists.

Conclusion: Staff within nursing/care homes understand the fundamentals of managing skin integrity and the importance of reporting skin damage; however, national education programmes are needed to develop knowledge and skills to promote patient health-related quality of life, and to reduce the healthcare costs of pressure damage. Further research to investigate understanding, knowledge and skills of nursing/care home staff concerning pressure ulcer development and safeguarding will become increasingly necessary, as levels of the older population who may require assisted living continue to rise.

Key Words

Pressure ulcers; safeguarding; nursing home; care home

Funding

Funding was received from NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (HMR CCG).

Karen McCormick is an employee of NHS Heywood, Middleton and Rochdale Clinical Commissioning Group

Background

Pressure ulcers and skin damage can affect any member of the population. The costs of treating and managing pressure damage have been reported in the literature^{1,2} identifying that costs increase dependent on severity of skin damage; the cost of treating a category 1 pressure ulcer will be approximately £1,214 rising to £14,108 for a category 4 pressure ulcer. Added to this will be an increased stay in hospital, increased community nurse visits and a reduction in health-related quality of life for those who have a pressure ulcer compared to those without³. Individuals living in nursing and care homes have a range of moderate and complex needs which are exacerbated if pressure damage occurs – resulting in reduction in mobility and activities of daily living, poor nutritional status, increased pain, reduction of quality of life outcomes and an increased financial cost to the care sector.

A proportion of pressure ulcers are avoidable: often related to the breakdown of individual elements of nursing. As such, they are considered a nurse-sensitive indicator of quality care⁴ and may be considered a safeguarding issue. However, although many pressure ulcers are reported to safeguarding teams, a proportion of these referrals are inappropriate, as staff do not possess in-depth knowledge of the role of safeguarding. A previous literature review⁵ using the key words *pressure ulcers* and *risk* and *nursing* and *care home* and *safeguarding* identified only five papers that investigated this area, with none of the final retrieved papers being focussed on the United Kingdom experience. The authors concluded that although there was a lack of literature investigating reporting of pressure ulcer development as a safeguarding concern in care and nursing homes, it was a key area of discussion for both commissioners and providers within healthcare, including nursing and care homes, warranting further attention.

This paper presents the results of a study exploring staff knowledge regarding appropriate referral to safeguarding teams in the event of pressure damage being recorded in a care/nursing home.

Methods

The study commenced in January 2015 and was completed in July 2015.

The aims of the study were to:

- I. Investigate whether staff in care and nursing homes regard pressure ulceration as a safeguarding issue;
- II. Explore reporting mechanisms for pressure ulcers in care and nursing homes;
- III. Investigate training needs of staff in care and nursing homes in relation to prevention and identification of patients at risk of skin damage.

Data collection was two-fold, using mixed methodology:

- I. Completion of a Bristol Online Survey questionnaire
- II. Semi-structured interviews

Ethics

Successful ethical approval to undertake the study was received from the University of Huddersfield School of Human and Health Sciences Research Ethics Panel and NHS Heywood, Middleton and Rochdale Clinical Commissioning Group. All participants were given an information sheet explaining the purpose of the study and were asked to sign a consent form. Completion of the Bristol Online questionnaire (BOS), (the BOS is used to conduct small or large scale surveys over the Internet, it is similar to Survey Monkey and is provided under licence from the University of Bristol) was recorded as the participant consenting to being involved in the study. Completed questionnaires were analysed at the University of Huddersfield. All data was stored securely on the University web server, password protected personal computers and encrypted memory sticks. Raw data from the questionnaires was deleted after analysis had been completed. Interview data was recorded and transcribed through the University of Huddersfield. Files were stored on the University of Huddersfield secure server.

Inclusion Criteria

1. Nursing or healthcare professionals who treat pressure ulcers, and are employed by Heywood Middleton and Rochdale (HMR CCG).
2. Agreement to be involved in the research.

Exclusion Criteria

1. Not a nursing or healthcare professional
2. Did not agree to be involved in the research

Data Analysis

Questionnaire data was collected from 65 respondents, the sample included both registered and unregistered staff members, across 50 care/nursing homes as detailed in Table 1. Semi-structured interviews were undertaken across four care and nursing homes (two care homes and two nursing homes) and interview data collected from 11 participants. The interview sample consisted of six Registered Nurses and five care assistants.

Results

Demographics

The questionnaire asked for respondents to identify their age, gender and job title. Responses are summarised in Table 1 below.

Table 1: demographic summary of participants (n=65)

Variable	Frequency (valid %)
Gender	
Female	59 (90.7%)
Male	6 (9.3%)
Age group	
18-30	19 (29.2%)
31-40	15 (23.1%)

41-50	10 (15.4%)
51-60	17 (26.2%)
60+	4 (6.2%)
Job title	
Registered nurse	8 (12.3%)
Care assistant/worker	31 (47.7%)
Senior care assistant/worker	12 (18.5%)
Manager/supervisor	6 (9.2%)
Other/not given	8 (12.3%)

The eight respondents who were registered nurses had been qualified for between 9 years and 42 years (mean 22.4 years; SD 13.7 years). All respondents were asked how long they had worked in their current position: answers ranged from 0 to 26 years, with a mean of 5.9 years (SD 5.5 years). Staff turnover was relatively low in the homes. Respondents were asked if they thought a high staff turnover and use of agency staff affected the incidence of pressure ulcer development. All the respondents reported that it was difficult to ensure continuity and quality of care if a high number of agency staff were being used, as: *‘these staff (agency) change from day to day and they do not understand the needs of the residents’*. All interviewees stated that in their respective workplaces there had been little staff changes over the last 12 months, and they had not been required to use agency staff.

Avoidable/unavoidable pressure damage

Respondents were asked how many incidences of pressure ulcers in their institution there were in the last 12 months, including Grades 1 – 4 ulcers, unstageable ulcers, and deep tissue injury. They were also asked how many of those ulcers were ~~un~~avoidable. However, many respondents provided a response only to the second question. In such cases, the frequency of all ulcers was considered to be the same as the frequency of avoidable ulcers; i.e. it was assumed that all observed ulcers were ~~un~~avoidable. Other respondents provided a response only to the first question. In such cases, the ulcers were not considered to be ~~un~~avoidable. Also, many respondents reported frequencies of zeros for certain categories of pressure ulcers and left cells for other categories blank. Disregarding these cells would have led to artificially high average incidences recorded for categories with high numbers of blank cells: hence no response to these items was treated as a zero observation.

It would be expected that disregarding blank cells would lead to inflated incidence figures as averages would be calculated based only on cells for which a response was received. However, we believe that in most, if not all, cases, a blank cell was indicative of a respondent who had not observed a particular type of pressure ulcer – there was no obvious clinical reason why any ulcer was theoretically impossible to occur in a given context; hence there should not really be any “not applicable” responses. Coding blanks as zero observations would bring the overall average incidence rates down.

Under these assumptions, the mean frequencies reported are summarised in Table 2 below.

Table 2: total pressure ulcers and proportion avoidable

Grade	Frequency of all pressure ulcers within last 12 months (Mean (SD))	Frequency of all pressure avoidable ulcers within last 12 months (Mean (SD))
1	1.52 (2.13)	0.58 (1.27)
2	0.58 (1.41)	0.37 (1.00)
3	0.14 (0.35)	0.11 (0.32)

4	0.29 (0.68)	0.18 (0.56)
Unstageable	0.05 (0.28)	0. (0.0)
Deep tissue injury	0.14 (0.35)	0 (0.0)
TOTAL AVERAGE INCIDENCES	2.72	1.24

Hence respondents judge on average 45.6% of incidences of pressure ulcers to be avoidable, leaving an average of 1.48 incidences within the last 12 months (54.4%) unavoidable.

During the interviews, all respondents stated that they had a very low incidence of pressure damage acquired in the care or nursing home, with the majority of pressure damage being evident when residents were admitted from either the community or an acute hospital environment. Nine of the respondents discussed the quality of written documentation and verbal communication they received prior to a resident returning home following a hospital in-patient stay. They expressed concern regarding lack of in-depth information received regarding the patients' skin integrity, both verbally and written.

Grading Systems

Respondents were asked if they used the European Pressure Ulcer Advisory Panel ⁶ (EPUAP)/National Pressure Ulcer Advisory Panel system ⁷ (NPUAP, or some other system, for grading pressure ulcers. Thirty eight respondents gave a definite answer to the question, with 27 respondents either reporting that they were not sure or giving no response. Of the 38 positive responses, 18 respondents (47.3%) reported using the EPUAP/NPUAP grading system, and an additional eight respondents (21.1%) reported using a different grading system. Of these eight respondents, four used care home devised grading systems and four did not state the procedure used.

Hence 26 respondents (68.4%) reported using some grading system, with 12 respondents (31.6%) reporting that they did not use a grading system. This was interesting as the majority of staff involved in this study were unregistered nurses and had been taught about grading systems through attendance at local study days and support of community and district nurses. Their ability to understand and be able to use grading systems effectively was to be commended.

Respondents were asked to estimate the total numbers of unavoidable and avoidable ulcers referred to their safeguarding team within the previous 12 months. For unavoidable ulcers, responses were ranged from 0 to 100, with a mean of 5.5 (SD 18.7). For avoidable ulcers, responses were ranged from 0 to 102, with a mean of 6.1 (SD 20.7). However, outlying values were reported by two respondents, who gave estimates of 100 and 70; and 40 and 102 respectively, greatly in excess of the estimates from other respondents. With these values excluded, the range of estimates was from 0 to 8 for both types of ulcers; for unavoidable ulcers, the mean estimate from 30 valid responses was 1.2 (SD 2.0); for avoidable ulcers, the mean estimate from 32 valid responses was 1.1 (SD 1.9). These may be compared with the mean estimates of incidence of 1.48 unavoidable and 1.24 avoidable pressure ulcers in the respondent's institution.

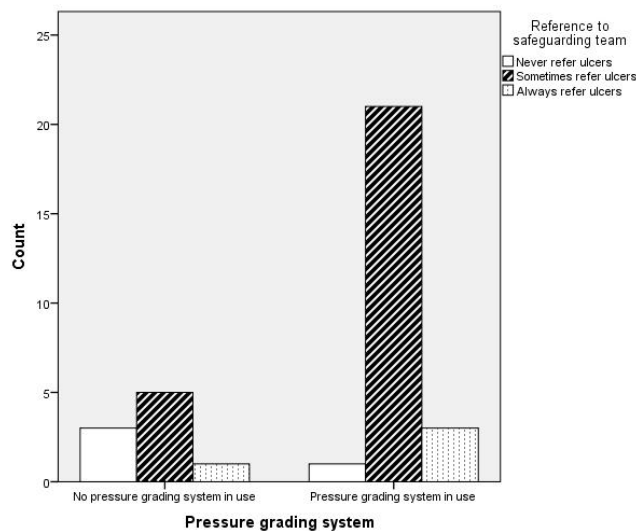
There were no differences between the estimates provided by carers and those provided by more senior staff (nurses/supervisors/managers).

Referral to safeguarding teams

The majority of respondents, all of the registered nurses and a large proportion of unregistered staff, would refer some, but not all ulcers to the safeguarding team (38 respondents; 71.7% of valid responses), this represented category 3 and 4 pressure damage. Fewer respondents would refer all ulcers (this included category 1 and 2 pressure damage)(8; 15.1%) or no ulcers (7; 13.2%). Twelve respondents did not provide a valid response to this item.

Some relationship was apparent between a respondent’s willingness to refer ulcers, and the existence or otherwise of a pressure grading system. Amongst respondents who reported the use of a pressure grading system, 24 out of 25 (96.0%) would refer ulcers some or all of the time. Amongst respondents who did not report the use of a pressure grading system, 6 out of 9 (66.7%) would refer ulcers some or all of the time. Hence the existence of a pressure grading system seems to be associated with a more willingness to refer ulcers; the association was of borderline significance at the 5% significance level ($\chi^2_{(2)}=5.55$; $p=0.063$). The relationship between the two factors is summarised in Figure 1 below.

Figure 1: relationship between existence of grading system and willingness to refer ulcers to safeguarding team



Understanding Safeguarding

Managers in all homes visited during the interviews were aware of safeguarding, and were making every attempt to inform and educate their staff. The emergence of a care home forum facilitated by the local safeguarding team was commended by managers. They believed that this had proved to be an effective support mechanism in understanding local and national safeguarding policy that they could then cascade to staff members in their work place. Unregistered staff (carers) would refer to the registered nurse or home manager if they were concerned about safeguarding, and not directly to the safeguarding team.

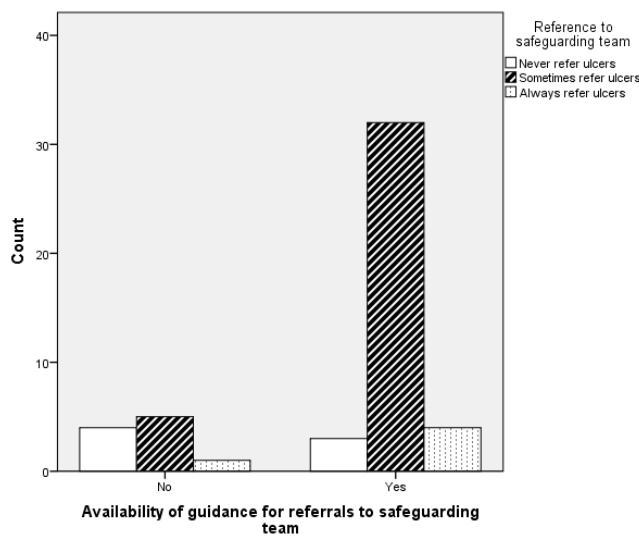
All 11 interviewees were asked what they understood by the term *safeguarding*. All respondents, with the exception of one carer, had heard of the term, and were able to explain it and its relevance to care delivered and to the residents. During the interviews, it became apparent that safeguarding was a priority for both the care and nursing homes visited. Each home had included safeguarding as

a standing item on their team meetings, and senior staff attended monthly safeguarding meetings with the local safeguarding team.

However there was confusion between ‘safeguarding’ and ‘safeguard’ within the care homes on the part of 4 interviewees. On exploration, when staff stated they referred pressure damage to the safeguarding team via the district nurses, it became obvious that district nurses were in fact not referring to the safeguarding team, but were documenting incidence of pressure damage on their electronic system: the ‘Safeguard mechanism’. This is the system used throughout the CCG for incidence reporting of pressure ulcers.

Forty one respondents (80.4% of valid responses) reported that guidance was in place to refer to when referring ulcers to the safeguarding team. Ten respondents (19.6% of valid responses) reported no guidance present. Unsurprisingly the provision of guidance was also associated with a willingness to refer: of those for whom guidance was provided, 36 (92.3% of valid responses) would always or sometime refer ulcers; of those for whom guidance was not provided, six (60% of valid responses) would always or sometime refer ulcers. The relationship was significant at the 5% level ($\chi^2_{(2)}=6.90$; $p=0.032$). The relationship between the two factors is summarised in Figure 2 below.

Figure 2: relationship between existence of guidance and willingness to refer ulcers to safeguarding team



All 41 respondents who reported that guidance was in place to refer to when referring ulcers to the safeguarding team reported that they had access to the policy. Of the ten respondents who reported that guidance was not available to them, five stated that no such guidance or policy existed within their organisation, and two stated that guidance or a policy was in existence but they did not have access to it. Three respondents did not provide a valid response to this item.

Communication

Communication between the acute hospital environment and care/nursing homes was discussed by the majority of interviewees (n=9). They highlighted the quality of written documentation and verbal communication received prior to a resident returning home following a hospital in-patient stay. They expressed concern regarding lack of in-depth information received regarding the patients’ skin

integrity. One manager explained that the discharge notes always stated that pressure areas had broken down or red areas were apparent on pressure areas. However, the grade of ulcer was not clearly defined, with the discharge documentation stating '*query grade*' rather than explicitly identifying that it was a grade 3 or 4. This lack of clear documentation made it difficult for the staff to order appropriate devices or contact community nurses/tissue viability teams to arrange timely visits. There was concern that when staff checked pressure areas of residents newly arrived at the care home, they would locate pressure damage that had not been documented by hospital staff. The homes (where the interviews took place) had developed guidance for all staff to ensure that prior to a resident being admitted to a hospital, all pressure areas had to be assessed, and written documentation of skin integrity made, including any signs of skin damage, pressure ulcers or reddened areas. This documentation was then referred to when the resident returned home.

One care home manager explained that in the home it could take upwards of 24 hours to order and receive a pressure redistributing device for a resident, and that this could be longer if it required ordering on a Friday or over a weekend. She stated that if hospital staff were able to offer detailed communication regarding pressure areas and any damage prior to discharge, it would afford them enough time to ensure the appropriate equipment was available prior to the resident returning home.

Training and Education

Interviewees were asked about training and education they had received in relation to safeguarding and pressure area management. The registered nurses reported that they had been educated regarding pressure ulcer prevention and treatment during their pre-registration education, but none had undertaken any formal courses since registration. Unregistered staff reported that they had received an introduction to wound management in their National Vocational Qualification training. Within one nursing home, a private company was employed to deliver pressure ulcer training and updates to both registered and unregistered staff annually via distance learning.

There was reliance on district nurses or the tissue viability specialist offering advice when a resident had skin damage, and attendance at link nurse meetings held at the local healthcare Trust to learn about effective management of skin integrity. There were no formal staff education programmes for tissue viability or wound management. Despite a lack of formalised education and training regarding pressure ulcer development and safeguarding, all respondents had attempted to maintain their knowledge by discussing issues with other professionals, reading journals and accessing the Internet for information. Each staff member was aware of the need to implement strategies that would assist in the prevention of skin damage, and was generally aware of safeguarding issues.

Discussion

The importance of care and nursing homes understanding and being able to identify and report potential safeguarding issues in a timely manner cannot be emphasised enough. The Flynn⁸ report published as a result of Operation Jasmine in Wales investigated poor care in a range of care homes. The report highlighted that families had perceived inattention to fundamental care interventions including hydration, nutrition, physical comfort, personal hygiene, unexplained injuries and deep pressure ulcers. The report concluded that the Welsh Government, in association with Public Health Wales, should guarantee that the significance of deep pressure ulcers was elevated to that of a

notifiable condition (Flynn, 2015: p.10). The report was unambiguous regarding the role of Safeguarding Adults Boards in their role of ensuring the Protection of Vulnerable Adults; stating they must be specific in their functions; strengthening protective outcomes for individuals where there is an allegation or evidence that harm has occurred, by ensuring that either a care assessment or a review of that individual's care plan is undertaken (Flynn, 2015: p.11).

The data collected in this project has highlighted that understanding and reporting safeguarding concerns related to pressure damage was a priority, reflecting guidance from the National Institute of Health and Social Care⁹ [NICE] who recommend that a culture in which reporting of safety and abuse concerns is understood as a marker of good care, and not just as a negative outcome of poor care. Additionally the NICE suggestion that safeguarding should be an integral aspect of induction training has been taken on board by each home. Indeed the homes have located safeguarding as a standing item on monthly meetings and annual mandatory update training for all staff.

A report published in 2015¹⁰ presents findings of Phase One of Measuring Quality in Community Nursing (QuICN), a national survey that describes the range, number and sources of Commissioning for Quality and Innovation (CQUIN) schemes applied to community nursing in 2014/15. The authors included pressure ulcer care in their data which was considered together with data from the National Safety Thermometer. However although the authors recognised that prevention and management are largely accepted as evidence of quality of nursing care in hospital and residential settings they found that they are often *'disputed as indicators of community nursing service quality as personal care has been removed from health services provision, with the nurse's role now being in clinical leadership, training and supporting social care partners providing care'* (Page: 4). The report concluded that local CQUIN schemes did offer service providers incentives to develop community nursing services, and facilitate increased communication and collaboration between a range of health and social care service providers to assist in meeting Government health priorities. During our study, participants had stated that they relied on community nurses and tissue viability nurses to offer advice regarding prevention, management and treatment of vulnerable pressure areas, so although Horrocks et al. had found this area of the community nursing had been removed from service provision¹⁰, there was evidence of collaboration and partnership between care home and community staff in education and clinical support. Indeed the introduction of a care home forum had been perceived as a positive outcome in building relationships between care home, community nursing and safeguarding teams that allowed for open discussion and sharing of ideas; in addition to forging effective partnerships in improving quality of care for care and nursing home residents.

Limitations

The authors recognise that this study was undertaken across one CCG only. However the large number (50) of representative care/nursing homes involved in the questionnaire should lead to a good degree of generalizability of results, with no home excessively weighting the sample. The level of data clustering was low (due to the wide range of homes represented in the survey) and there was no evidence that included homes were not representative of the wider population of care/nursing homes.

The 11 interviews undertaken allow for future exploration and may form the basis for a wider investigation.

Recommendations

The authors recommend that further research is undertaken in care and nursing homes across the UK to identify knowledge and skills gaps in relation to pressure ulcer prevention and identification of skin damage that requires referral to safeguarding teams. NHS England¹¹ (2015; p7) have been explicit in that *'any pressure ulcer that meets, or potentially meets, the threshold of a Serious Incident should be thoroughly investigated to ensure any problems in care are identified, understood and resolved to prevent the likelihood of future recurrence. This requires an assessment of whether any acts of omission or commission may have led to the pressure ulcer developing'*. This statement refers to all categories of pressure damage and not just categories 3 and 4, which the majority of organisations already report as serious incidents and undertake root cause analysis for. NHS England warned that classifying all category 3 and 4 ulcers as Serious Incidents could lead to a 'burden of investigation' and as such assessment of the circumstances of each case of pressure damage, including those categorised as a 1 or 2, must be made and documented clearly highlighting consequences for the patient. There is an essential need for safeguarding teams to work closely with staff in care and nursing homes to highlight the role of safeguarding teams and to provide support in the prevention of incidences similar to those described in the recent Flynn report. Indeed the importance of community nursing staff, tissue viability and safeguarding teams working together in an inter professional manner cannot be over emphasized There must be a sharing of information, education and reporting mechanisms that are clear to ensure that pressure damage is identified in a timely manner and that all professionals understand and appreciate what constitutes a serious incident; what is a safeguarding concern and that protection of vulnerable adults is every professionals responsibility.

Conclusion

There is little research and evidence that investigates the understanding, knowledge and skills of care and nursing home staff in relation to pressure ulcer development and safeguarding⁵. This is a clear gap in existing literature that requires addressing; especially as the level of the older population who may require assisted living in the future in care/nursing homes continues to rise. Staff within care/nursing homes understand the fundamentals of managing skin integrity and the importance of reporting skin damage to community nursing staff and/or safeguarding teams; however, there needs to be a national programme of education to support these staff in maintaining and developing their knowledge and skills to promote health-related quality of life outcomes for residents, and to reduce the financial burden to healthcare of pressure damage.

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