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DOI:

[10.1108/JAP-11-2016-0029](https://doi.org/10.1108/JAP-11-2016-0029)

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Citation for published version (APA):

Manthorpe, J., & Martineau, S. J. (2017). Pressure Points: learning from Serious Case Reviews of failures of care and pressure ulcer problems in care homes. *Journal of Adult Protection*, 19(5), 284-296.
<https://doi.org/10.1108/JAP-11-2016-0029>

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Jill Manthorpe and Stephen Martineau

Pressure Points: learning from Serious Case Reviews of failures of care and pressure ulcer problems in care homes

Abstract

Purpose: Serious Case Reviews (SCRs, now Safeguarding Adults Reviews (SARs)) may be held at local level in England when a vulnerable adult dies or is harmed, and abuse or neglect is suspected, and there is cause for concern about multi-agency safeguarding practice. There has been no analysis of SCRs focussing on pressure ulcers. This article presents findings from a documentary analysis of SCRs/SARs to investigate what recommendations are made about pressure ulcer prevention and treatment in a care home setting in the context of safeguarding. This analysis is presented in cognisance of the prevalence and risks of pressure ulcers among care home residents; and debates about the interface of care quality and safeguarding systems.

Design/Method: Identification of SCRs and SARs from England where the person who died or who was harmed had a pressure ulcer or its synonym. Narrative and textual analysis of documents summarising the reports was used to explore the Reviews' observations and recommendations. The main themes were identified.

Findings: We located 18 relevant SCRs and one SAR covering pressure ulcer care in a care home setting. Most of these inquiries into practice, service communications and the events leading up to the death or harm of care home residents with pressure ulcers observed that there were failings in the care home, but also in the wider health and care systems. Overall, the reports reveal specific failings in multi-agency communication and in quality of care.

Research limitations/implications: Reviews vary in content, structure and accessibility making it hard to compare their approach, findings and recommendations. There are risks in drawing too many conclusions from the corpus of Reviews since these are not published in full and contexts have subsequently changed. However, this is the first analysis of these documents to take pressure ulcers as the focus and it offers valuable insights into care home practices amid other systems and professional activity.

Practical implications: This analysis highlights that it is not inevitably poor quality care in a care home that gives rise to pressure ulcers among residents. Several SCRs note problems in wider communications with healthcare providers and their engagement. Nonetheless, poor care quality and negligence were reported in some cases. Various policies have commented on the potential overlap between the raising of concerns about poor quality care and about safeguarding. These were highlighted prior to the Care Act 2014 although current policy views problems with pressure ulcers more as care quality and clinical concerns.

Research implications: The value of this documentary analysis is that it rests on real case examples and scrutiny at local level. Future research could consider the findings of SARs, similar documents from the rest of the UK, and international perspectives.

Originality/Value: The value of having a set of documents about adult safeguarding is that they lend themselves to analysis and comparison. This first analysis to focus on pressure ulcers addresses wider considerations related to safeguarding policy and practice.

Conclusions: Pressure ulcers featured in several SCRs, but it is problems and inadequacies with care and treatment that moved them to the safeguarding arena. The value of examining pressure ulcers as a key line of inquiry is that they are 'visible' in the system, with consensus about what they are, how to measure them and what constitutes optimal care and treatment. In the new Care Act 2014 context they

may continue to feature in safeguarding enquiries and investigations as they may be possible symptoms of system failures.

Introduction

There have been several debates in England about the threshold for a safeguarding enquiry and investigation both under the Care Act 2014 and previously (Collins 2010). The demarcation between poor care and treatment and abuse or neglect is particularly hard to define and operationalise, especially in long-term care facilities such as care homes. This is illustrated in debates about the appropriate response to pressure ulcers, with the Department of Health clearly indicating that these should be seen as a clinical rather than a safeguarding subject (Crawley 2016). They are described as highlighting '*the contested issue of adult safeguarding's responsibilities in relation to poor care*' (Valios 2014).

There is general consensus that pressure ulcers (sometimes referred to as pressure sores, decubitus ulcers or bedsores) are painful and distressing yet, in many circumstances, preventable or treatable (Gorecki et al 2009). Some 700,000 people in the UK are affected annually, with 20 per cent of long-term care residents being at risk, as estimated by the NHS campaign Stop the Pressure (2013). Launched in 2013, this campaign is exhorting the need for pressure ulcer prevention in the NHS and other settings.

This article reports the findings of an analysis of Adult Serious Case Reviews (SCRs) in England where pressure ulcers were noted as affecting the individual resident concerned or their presence was commented upon in the Review. The Reviews' comments on the care and treatment offered to the individual and professional communication, information and other responses are explored. Relevant recommendations are presented and discussed. While our focus is on pressure ulcers in care home settings, such problems arise in community and hospitals settings. One prominent example of hospital

patients' experiences of pressure ulcers featured in the inquiry into Mid Staffordshire NHS Foundation Trust (Francis 2010, pp 95-97).

Background

Definitions

A pressure ulcer is defined as 'localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear' (European Pressure Ulcer Advisory Panel 2009). In the UK the gradation of pressure ulcers is fourfold, grades/categories 1-4, with 4 the most severe (ibid). NICE (2014) recommends that practitioners consider using a validated scale to assess ulcer risk and support their clinical judgement, such as the Braden scale, Waterlow score, or Norton risk assessment scale.

Numbers and prevalence

Newly acquired pressure ulcers among patients being cared for by the NHS or who are NHS funded are reported in the NHS Safety Thermometer (NHS Digital 2017) using data that is recorded monthly for every NHS funded patient in participating organisations (including those in care homes). The NHS Safety Thermometer reported that the numbers of pressure ulcers reported in the period February 2016-February 2017 stood at 107,713 in English NHS, acute and community settings (Table 3).

The Office for National Statistics (ONS 2013) reports decreasing fatalities from pressure sores/decubitus ulcers. The numbers of deaths where pressure sores/decubitus are noted as a contributory factor fell from 1,006 (in 2010), to 841 (in 2011) and to 771 (in 2012). Mentions of them as the underlying cause of death fell from 230 (in 2010), to 127 (2011) and 96 (2012) (figures in respect of England and Wales).

The prevalence of pressure ulcers in care homes is hard to interpret since areas collect data in different ways within the UK (Stevenson et al 2013). It is generally agreed that the substantial disabilities of most

care home residents place them at risk of pressure ulcers (Gordon et al 2014). A Norwegian study found that in nursing homes, despite the risk factors affecting many residents and the higher prevalence of pressure ulcers in these settings, prevention was hampered by staff's limited competence and a lack of preventative equipment such as beds and chairs (Johansen et al 2015).

Care home populations

The English care home sector is predominantly commercial (Burns et al 2016). Residents may be self-funding or their fees paid by the local authority, at times with NHS contributions. The sector was mainly subject to the Care Standards Act 2000 and its regulations in the period covered by this present study. Currently it is regulated and inspected by the Care Quality Commission. Residents are entitled to NHS services, although NHS provision and arrangements for residents vary (Goodman et al 2015).

A recent United States (US) study (Liao et al 2010) investigated whether 'full-thickness pressure ulcers' occur even in excellent care in long-term care facilities. Using data for 24 residents who had developed a severe pressure ulcer in a facility where care was agreed to be good, they found no single ulcer characteristic to differentiate an ulcer that had developed under a good care regime from one under poor care, with the possible exception that a second full-thickness ulcer did not appear to occur under good care. They concluded that the presence of a single full-thickness pressure ulcer '*cannot and should not be used by itself as an indicator of poor care. Rather as in most forensic situations, the overall pattern of care is more important than a single physical finding*' (p31; and see also: Baker et al 2016).

Serious Case Reviews and Safeguarding Adults Reviews

In England a Safeguarding Adults Review (SAR) must be undertaken when an adult with care and support needs dies, abuse or neglect is known or suspected to be the cause of death, and there is reasonable cause for concern about how the agencies worked together to safeguard the adult; this new

duty also extends to cases where the adult is still alive, the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect, and there is concern about the quality of joint working (s 44, Care Act 2014). Formerly there was discretion to undertake a Serious Case Review (SCR) in similar circumstances. Details of SCRs have been collected and different facets examined, such as SCRs in supported housing (Parry 2014), self-neglect (Braye et al 2015), dementia care (Manthorpe and Martineau 2016a) and care homes (Manthorpe and Martineau 2016b). At the time of writing (early 2017) a small number of SARs have been published (among which Winter 2015 was included in this present analysis although the setting was described as supported accommodation). SCRs remain an important body of detailed investigation about the care and treatment of vulnerable people, although not all were published in full and they vary in depth, focus and approach. Sixty SCRs were reported to the Health and Social Care Information Centre in 2013-14, 65 in 2014-15, and 90 SARs in 2015-16 by local authorities (NHS Digital 2016). There has been no analysis of SCRs focussing on pressure ulcers.

Patient Safety

In addition to their contribution to patient suffering and death, the costs to the NHS of mainly avoidable conditions such as pressure ulcers are high. The Stop the Pressure initiative (2013) collates resources and educational initiatives. This NHS campaign deems the presence of pressure ulcers a serious clinical incident which must be investigated and reported. NHS Improvement (2010) issued a National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, followed by NHS England's Serious Incident Framework (NHS England 2015). From 1 April 2016, the National Patient Safety Agency joined NHS Improvement. These reorganisations indicate some of the changing NHS contexts relevant to the analysis of the SCRs considered in this present paper. Several of the SCRs' recommendations were directed to organisations and systems that were current at the time of their publication and should be seen in this context. In the care home sector pressure ulcers are reportable to

the regulator under Regulation 37 of Care Standards Act 2000; primary care acquired pressure ulcers in commissioned independent providers should be reported by the commissioning organisation (West Midlands Strategic Health Authority 2011, p8).

The threshold debate

A final piece of the background jigsaw is the debate about whether pressure ulcers are germane to safeguarding and if so in what ways. Prior to the Care Act 2014, a Social Care Institute for Excellence (SCIE) guide observed that pressure sores were:

... not always due to neglect and each individual case should be considered, taking into account the person's medical condition, prognosis, any skin conditions and their own views on their care and treatment. These things, rather than the grading of the pressure sore, should determine whether a safeguarding referral is appropriate. Other signs of neglect, such as poor personal hygiene and living environment, poor nutrition and hydration may help to influence this decision. (Cass 2012, p.3) (authors' note - this is often repeated in local documents often without attribution).

In the context of the Care Act 2014, a set of practice questions and answers was included in SCIE resources (SCIE 2015). One stated *'The simple fact that an adult at risk has a pressure ulcer – even a serious one – is not in itself a reason to suspect abuse or neglect.'*

The 'official view' of the Department of Health (DH) is summarised in the abstract of a conference presentation by Claire Crawley (2016), then Senior Policy Manager Adult Safeguarding DH, stating:

Care Act safeguarding enquiries and duties are not the default position for responding to pressure ulcers. Informed professional judgement is critical in prevention and responding to pressure ulcers. All agencies and organisations need to do much more about preventing

pressure ulcers but also understanding the truth and myths about them. Focus should be on protecting the individual from harm, not the organisation from blame. Commissioners of care and support need to specify in detail the need for skin care and regular review. We need to give much more thought to training and awareness, especially in the social care workforce but also informal and family carers. Safeguarding Adults Boards should have agreed protocols with the health and care sectors about the interface between safeguarding and treatment of pressure sores. SABs could usefully monitor trends in prevalence to identify what further preventative work can be undertaken.

In an earlier policy presentation reported in *Community Care* (Valios 2014) Crawley urged delegates not to treat pressure sores as safeguarding concerns other than in rare circumstances of neglect. This was followed up by online comments containing strongly supportive but also dissenting views (see Valios 2014).

Methods

Adult SCRs were not generally published in full and their executive summaries vary in terms of whether they include details of the incident(s), provide any chronology of events or detail communication and any expert (second) opinion or evidence. They could be single or multi-authored; and reports of their hearings or the materials considered are not available for scrutiny. We undertook a documentary analysis of all obtainable Adult SCRs and SARs undertaken in England from 2003 to August 2016, searching for direct or indirect mentions of pressure ulcers, bed sores, or pressure sores (or other indications such as tissue or skin breakdown or terminology such as necrotic sores or sores) in the resident who experienced harm or had been placed at risk. We compared our list with a catalogue of SCRs (Clay 2014) to see if any had been missed but none appeared to have been. We adapted the categories adopted in previous documentary analyses of Adult SCRs (Manthorpe and Martineau 2015,

2016a, 2016b). These elements or categories covered the SCR rationale, details of the 'victim' and of alleged abuse or poor practice, the setting and its contexts, practitioners and other parties, its findings and recommendations. Reading and re-reading of the SCRs were undertaken in August 2016 to consider these intra (elements within the SCR report) and inter (comparisons between SCRs) organisational categories. While most care home residents are older people, we did not focus on this age group alone. In some SCRs, age is not given but general terms such as 'elderly' or 'older' are sometimes employed. Most SCRs use initials for the person involved or pseudonyms. Few provide details of ethnicity or sexuality. We have noted in Table 1 whether the care home was a care home with or without nursing (using CQC registration categories) or if it was dual registered (to provide care and nursing or only care for some residents) if this information was contained in the SCR/SAR.

Findings

We located 17 SCRs and one SAR of interest (see Table 1). We excluded Harrington's (2013) summary of the SCR concerning a Mr J as he was only briefly (2 months) in a care home. While there is mention of multiple injuries and possible pressure sores of varying ages, these appeared to have been acquired at home (we have recently completed a study of home acquired pressure ulcers and SCRs). We also excluded Lawson's (2012) SCR re JT since the main concerns about pressure ulcer care related to the domestic home setting not a long-term care facility. The number of SCRs/SARs analysed in this present paper is therefore 15. This does not equate to the numbers of residents affected since some SCRs cover more than one resident's care and comments are made in some about the possibility that the matters uncovered affected the whole home. One SCR (Phillips 2013) mentioned pressure ulcers as being appropriately treated and we do not discuss its broader findings; although this provides evidence that pressure ulcers should not be used as a 'barometer' of care quality. We located one SAR (Winter 2015) containing a brief mention of care practice in preventing pressure ulcers (eg applying cream following

bathing) but as the review focused on a fatal choking incident in a supported living facility, this SAR is not considered further. The report of a minor pressure ulcer in the SCR re 'Bill' (Cumbria Safeguarding Adults 2009) was not explored and we make no further comment on this since it was deemed minor and was not the focus of the Review.

Poor care quality

Problems with care quality were found by two SCRs undertaken by Bedford Borough & Central Bedfordshire Safeguarding Adults Board (BBCB) (2009a; 2009b). The first concerning Mr R led to a Council review of care homes and suspension of funding until acceptable standards were operating. This SCR found poor training and inadequate multi-agency responses to tissue viability concerns. It *recommended* that self-funders must receive appropriate support from social work staff and other professionals, including contract monitoring staff.

The second (BBCB 2009b) concerned a Mr S who had multiple pressure sores and died following their infection. The coroner described the nursing care received as 'woefully inadequate' and death was 'for want of care by those charged with it' (p1). The SCR *recommended* that community care assessments must be recorded and communicated promptly to all parties. The same standards for assessment, care management and support should be applied to self-funders as to publicly funded ones. Care homes should be reminded of importance of regular reviews and sharing of information. Policy and procedures for tissue viability should be reviewed. It *recommended* a risk assessment, review and a SOVA (Safeguarding of Vulnerable Adults) referral (p2) of all pressure ulcers.

An example of a 'failing home' followed concerns over care and safety standards in a family owned care home and two fatal incidents in Devon (White 2011). Amidst a catalogue of problems, a high incidence of pressure sores was noted by the SCR. The actions of professionals attending the care home were criticised, with the Community Nursing Service; Adult Community Services; GPs; police; ambulance

service; local Partnership Trust; and the inspectorate failing to recognise problems: *'This case raises awareness of the role agencies should play in being the 'eyes and ears' for safeguarding when visiting establishments on a regular basis, and emphasises the importance of reporting concerns'* (p8). In the case of the GP practice, nine different GPs attended the care home. Pressure ulcers were not proved to be the cause of death, but provided cause for concern about institutional neglect: since the poor standard of care was considered to be evidenced by incidence of pressure ulcers, for example, the care home manager had failed to report four incidents of pressure ulcers (p4). One pressure ulcer was attributed to lack of correct equipment. This SCR *recommended* that the development of Grade 3 or 4 pressure ulcers in a care home should always result in consideration of need for a safeguarding alert and that the outcome of this consideration should be documented.

Poor quality care is not always substantiated by simple references to pressure ulcers but mentions of them are noted by many SCRs. In the SCR of Orchid View (Georgiou 2014), registered as a care home with nursing, they are referred to as clear instances of poor care: *'This investigation focused on a similar range of poor practices as those in previous investigations with residents with pressure sores, poor quality dressings, low staffing levels, staff sleeping at night and rudeness towards residents'* (p45). For relatives they may seem specific, visible, and 'provable' demonstrations of poor care:

Mr D had been in Orchid View for some two weeks for respite when he was taken to hospital, and he died shortly afterwards. Both his wife and their friend expressed their concerns to the social worker during the investigation in relation to the care he had received at the home and that a pressure sore had developed while he was at the home. (p42)

Similarly the Elm View Care Home SCR (Calderdale Safeguarding Adults Board 2014) made several mentions of pressure ulcers developing amid unresponsive care and treatment (eg no pressure relieving mattress). Policy that pressure ulcers of Grade 3/4 should be made a safeguarding alert had not been

followed (p7). It appeared that the Care Quality Commission had received information about a pressure ulcer (p8) and that anonymous allegations about poor care had made reference to it. The media referred to pressure ulcers specifically when reporting the criminal trial: '*Cruel care home owner and nurse who left elderly and vulnerable people in their care in agony with bedsores*' (Mail Online 2013).

Arriving with pressure ulcers

In contrast a small number of SCRs noted that while the resident might have a pressure ulcer it had likely developed before their move to the care home. Concerning Adult B, for example, Nottinghamshire Safeguarding Adults Board (2011) found that her severe pressure ulcers had developed while she was living in her own home. Adult B was noted to be at risk of pressure sores although the risks arising from her nutritional needs and need for pressure care were not fully appreciated by care providers. Following a two-month stay at home, she returned to the care home with weight loss and 'severe pressure sores' (dying soon after), with a verdict of death by natural causes, contributed to by neglect. The district nursing service was considered to not have been sufficiently proactive in assessment and treatment planning with regard to prevention and to have provided a poorly coordinated response to tissue deterioration. NICE guidelines had not been followed and dressings used did not promote optimal wound healing.

The main *recommendation* was for a single robust assessment process and better cooperation between health and social care, with the view that an overall care coordinator could have improved the assessment process and reduced the risks for Adult B. Staff completing tissue viability care plans were *recommended* to follow best practice guidelines.

Care capacity

Some SCRs acknowledged that residents may have increasingly complex health and care needs. One SCR (Oliver 2012) investigated the care and treatment of a resident, William Lawrence, who had a significant learning disability, was blind, and had early dementia. He had lived with parents until moving to a care home (Berrywood Lodge) in 1997 aged 36. Prior to his death in hospital, his father had raised concerns about his care. The SCR reported:

Berrywood Lodge acknowledges that staff were not competent to correctly assess risks, identify controls or carry out evaluations. They also acknowledge the increasing risks associated with William's deteriorating position which could have been reasonably foreseen, were not highlighted and indicate risk assessments did not cover areas such as moving and handling or sufficient details around pressure care. Systems for audit, monitoring and compliance of risk assessments were not evident. Berrywood Lodge make the point that they did access other agencies for support and were dependent on other professionals for support or in some cases effecting decisions pertinent to William. (p4)

One example of the lack of risk assessment and other agencies' lack of support was the wheelchair service's unsuccessful request for pressure ulcer assessments. The SCR observed confusion between compliance and safeguarding, but also noted that records were missing and information was incomplete. It *recommended: 'When complaints are received where there is an inference of neglect, the Safeguarding process should be triggered'* (p14).

In acknowledgement of another home's limited capacity to care for a resident's increasing needs, a Mrs DN (Dorothy) was moved from the care home where she had lived for five years to one with nursing care on site (this turned out to be two days before her death). The SCR (Williams 2010) questioned whether increased community nursing could have enabled her to stay in the care home, or whether a better assessment may have allowed her to move earlier, which it acknowledged would have been '*an*

extremely complex task' (p21). It raised the possibility that her self-funding status might have delayed assessment and consideration of the adequacy of her care. A developing Grade 4 pressure ulcer was being treated in the weeks before her death:

The trigger to the formal safeguarding investigation in January 2009 was the discovery of the pressure sore on Dorothy's heel. Was the extent of the sore as a result of neglect by staff at the care home and/or by poor professional oversight and treatment of this pressure sore by district nurses? The more general concern was whether the care home was registered to meet the needs that Dorothy had developed and had sufficient expertise to meet those needs safely (p8).

Multi-agency processes and policy

The above SCR *recommended* improving inter-agency working to better safeguard vulnerable adults, especially if there was a Grade 4 pressure ulcer (Williams 2010 p31). Vickers (2010) identified a resident's (case A) pressure sores and deterioration, finding that care reviews had not been conducted regularly and termed this a '*critical*' failure. There had been insufficient monitoring by the NHS or Council to prevent or identify institutional abuse. This SCR *recommended* that care homes should ensure all nursing staff are aware of NICE (National Institute for Health and Care Excellence) and other guidelines and be trained to follow guidance. Further it *recommended* that care homes should call in tissue viability specialists when residents develop pressure ulcers, regularly check tissue viability, and record their presence in care plans.

The question of the proper threshold for a safeguarding alert was not addressed by the SCR concerning a Mr A (O'Brien 2010), a self-funding resident, although an alert had been raised by a GP who reported

that Mr A had diarrhoea for 3 months (actually 3 days). The SCR noted that his skin condition was being managed by the care home (with nursing), but found several poor practices:

Notes in the daily planner were spasmodic and sometimes inadequate. There was a lack of a comprehensive care plan on nutrition, failure to obtain either Mr A's or his family's signature on his care plans, the use of an inadequate risk assessment tool and a failure to record all the visits made by medical professionals including the GP... There were instances of poor communication between medical professionals and the nursing home. Visiting medical professionals had not always recorded findings and advice in the patient's notes in the nursing home in addition to their own electronic notes nor had they formally recorded with evidence or reported any concerns they may have had about the nursing home. There was a lack of information on medical history and current medication available to emergency and out of hours doctors visiting nursing home residents and a lack of clear information on the referral route to hospital. (p3)

This SCR *recommended* that in care homes with nursing '*Where a resident has compromised nutritional intake, an appropriate care plan to be in place including regular weighing*' (p4). It recommended that the Waterlow Assessment tool replace the Braden Assessment tool and that overall record keeping should be improved. Further recommendations were made to hospitals (about improving patient notes) and to community services.

Examples of further problems in care co-ordination came from the SCR re Adult D (Nottinghamshire SAB 2010). While the coroner's verdict was of death by natural causes, contributed to by neglect, the presence of pressure ulcers featured several times. Although plans for pressure area care had been formulated, risks did not appear fully assessed (p5) and the use of tissue viability equipment was considered too late. While agencies had guidelines on pressure area care, it was unclear whether these

were adhered to or best practice followed. There appeared little recognition of the risks of nutrition problems and weight loss. *Recommendations* were to develop a checklist of early warning signs of pressure ulcers and that all care providers should be able to demonstrate best practice in tissue viability management. This SCR's main *recommendation* was for one individual professional to co-ordinate overall care. This echoed the *recommendation* made by an earlier SCR about the need for one agency to have a holistic picture – which it judged would have triggered an earlier adult protection alert (East Sussex County Council 2005).

The SCR concerning Cases A and B (Kent & Medway Safeguarding Vulnerable Adults Committee 2009) covered similar terrain by observing delays in ordering pressure relieving equipment, collecting prescribed special dressings and seeking expert advice. It *recommended* that training about pressure ulcers should be given to adult safeguarding staff and the police to ensure they understand when pressure ulcers are indicators of poor care (p8). As noted above, similar findings were made by BBCB (2009a).

Discussion

This analysis identifies failings in multi-agency working as well as problems with individual practices. This is unsurprising since the general rationale for a SCR was to investigate any failings in local agencies' working together to safeguard adults at risk. Other themes include not adhering to NICE guidance and delays in response. Some indications are made that the self-funding status of residents might have affected overall care co-ordination. Relatives appear to have notified authorities in some cases of their concerns that pressure ulcers were not being managed appropriately. It is evident that in some areas there were policies and procedures stating that some (severe) or all pressure ulcers should be reported

as a safeguarding alert. We do not know how many were, but some SCRs comment on occasions when these policies were not followed.

From the US, the Liao et al (2010) report shared many of these observations by exploring the minimum data set for care home residents to determine quantifiable data about pressure ulcers. They highlighted the wide-ranging problems of pressure ulcers in US care settings:

Pressure ulcers in long-term care facilities represent a significant problem with medical, economic, legal and quality of life implications. Pressure ulcers are currently used as an indicator of quality of care and are part of the required Minimum Data Set that long-term care facilities must report. Internally long-term care facilities utilize pressure ulcers as a quality control indicator and have developed policies for pressure ulcer prevention, assessment, and treatment as part of their quality improvement process. Externally public and private entities look at pressure ulcers as a measure to hold facilities accountable for the care they provide. (Liao et al 2010, pp 1-2).

In the UK there is no such Minimum Data Set about long-term care residents and we do not know how far legal redress extends in the UK context.

Limitations: The limitations of this paper are those of other SCR analyses in that the documents vary in size and depth rendering comparison difficult. There are risks in drawing too many conclusions from SCRs since many were not published in full and contexts have subsequently changed. There may be other SCRs and SARs that were not accessed through our searches. However, this first examination has helped to clarify that pressure ulcer risks are faced by many care home residents yet healthcare skills and support are not always available or optimal. It has also identified that the presence of ulcers and their grading system seem to be used as indicators of poor care if responses to them are sub-optimal. Examples are given in some SCRs of delays in response, poor care and negligence. It may be that

because a pressure ulcer is visible, and the severity of it can be categorised, it is a less subjective indicator than other manifestations of neglect or poor care quality. The SCRs do not generally report that the safeguarding alert was made unnecessarily but it would likely be impossible to expect them to do so since SCRs are commissioned where harm or risk of harm is serious enough to warrant such a review and in contexts where there is suspected to have been multi-agency failings in safeguarding. Post Care Act 2014, there may be less variation in local policies and procedures about the threshold for a safeguarding concern, and the outcomes of this shift need monitoring. Finally, with an eye to the future, those undertaking or commissioning Internal Management Reviews (prior to a SAR) and a SAR may wish to satisfy themselves that they have access to tissue viability expertise if they are investigating the prevention, care and treatment of pressure ulcers so that they can be confident that they can distinguish between poor practice, ill-designed systems, dilemmas, a lack of resources and positive risk taking.

Conclusion

The SCRs considered in this paper reflect the diversity of care home provision and their residents. We have highlighted the risks of pressure ulcers among care home residents thus making problems in care quality particularly serious for residents. The analysis has shown that problems in prevention and treatment are not solely attributable to care home staff but to the extent to which they are supported by NHS professionals, and the wider problems of the sector which make communication, information sharing, accountability and resource provision difficult. We found some variations in recommendations about whether pressure ulcers should trigger a safeguarding enquiry but the evidence from SCRs mainly relates to the pre-Care Act implementation period. SARs might usefully be scrutinised for their findings about appropriate thresholds for referrals to safeguarding and the effectiveness of the Care Act changes to thresholds.

Acknowledgements and disclaimer

This study was undertaken as part of the Social Care Workforce Research Unit's programme of research for the Department of Health's Policy Research Programme. The views contained in this article are those of the authors alone and should not be seen as necessarily reflecting the view of the Department of Health.

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Table 1: Serious Case Reviews (SCRs) / Safeguarding Adults Reviews included in initial analysis

Author, date	Name / Pseudonym: age, gender	Living situation as referred to in the SCR	Condition of person	Incident/s and circumstances relevant to call for a Serious Case Review; mention of pressure ulcers
Bedford Borough & Central Bedfordshire Safeguarding Adults Board, 2009a	Mr R: 87	Care home	Had suffered a stroke. Predominantly bed/chair bound.	Cause of death (Coroner): sepsis, pressure sores, historical illness, stroke.
Bedford Borough & Central Bedfordshire Safeguarding Adults Board, 2009b	Mr S: ?age,	Care home with nursing	Incapacitated by rapidly deteriorating physical and mental health according to the Coroner	Cause of death (Coroner): sepsis, infected multiple pressure sores, dementia, and Parkinson's disease.
Calderdale Safeguarding Adults Board, 2014	Elm View: most over 80	Nursing home	A range of long-term physical conditions, often with multiple co-morbidities and reduced mobility. Many of the residents had a degree of dementia.	Escalating concern about standard of care at the home (owner and manager both subsequently found guilty of wilful neglect); a number of concerns about pressure sores had been raised
Cumbria Safeguarding Adults, 2009	Bill: 87	Daughter's home / Care home (for respite care)	In 2003 Bill stopped living independently to live with his daughter, with intermittent respite care and several hospital admissions	Died as a result of pneumonia and chronic obstructive pulmonary disease. Concern raised about standard of respite care. On final hospital admission nursing staff noted an early stage sacral pressure sore
East Sussex County Council, 2005	P.L.: 93, female	Nursing home	P.L. suffered a series of falls at the nursing home	At hospital admission from nursing home P.L. had sepsis, dehydration, multiple pressure sores, urinary tract infection. Pressure sores 'contributed significantly to her death' (pathologist's report)
Georgiou, N, 2014	Orchid View: older people	Nursing home	Home for older people and people with dementia	While it was open (2009-2011) there were several safeguarding alerts and investigations (included concerns about pressure sores and pressure relief). In 2013 a coroner found that neglect was involved in the deaths of five residents, and that

				others who had died had experienced suboptimal care.
Harrington, K, 2013	Mr. J.: 59	Care home and own home	Alzheimer's disease and alcoholism	Admitted to hospital with multiple cuts, bruises and possible pressure sores of varying ages, and extremely dehydrated. He had multiple injuries to his brain.
Kent & Medway Safeguarding Vulnerable Adults Committee, 2009	A and B: older, male and female	Care home	Older man with Parkinson's Disease; older woman with dementia	2 separate cases of pressure sores, but not described as cause of death.
Lawson, J., 2013	J.T.: ?age, female	Care home with nursing (after a care home)	Suffered first stroke 1990. Range of health conditions	Died of a stroke 2012. Reluctant to receive services. Concern about pressure ulcers date from when she lived at home
Nottinghamshire Safeguarding Adults Board, 2010	Adult D: 70+, female	Care home	Frail, elderly lady with multiple serious medical conditions	Coroner: natural causes contributed to by neglect. Cause of death was given as septicaemia, arising from gangrenous pressure ulcers.
Nottinghamshire Safeguarding Adults Board, 2011	Adult B: 80+, female	Care home and own home	Older with history of falls; arthritis	Severe pressure sores, which developed while she was at home. Coroner's verdict: death by natural causes, contributed to by neglect
O'Brien, C., 2010	Mr A: elderly	Nursing home	Several falls, chronic obstructive pulmonary disease and anxiety	Skin condition and misinformation about diarrhoea
Oliver, J., 2012	'William Lawrence': 51	Care home	Had Down's syndrome, learning disability, early onset dementia, registered blind	Admitted with sores, dehydration, and infections. Concern about level of intervention, care and support
Phillips, J., 2013	Wyton Abbey Care Home	Care home	Adults over 65; including those with dementia)	Serious concerns had been expressed about the condition of one resident at the time of their death – coroner avers that he might not have died if he had received more timely help. Also concerns about the care of two other residents.
Vickers, R., 2010	A: 81, male	Care home with nursing	Chronic obstructive pulmonary disease since 1987 and had a right	Cause of death: Pulmonary disease and infected pressure sores. Adult safeguarding

			sided stroke in 1998	conference found that he had been victim of institutional abuse – including physical abuse and neglect through pressure ulcers
White, D., 2011	Care home for older people	Care home	Elderly and/or people with dementia. Family owned home for up to 12 residents	Concerns about standards of care, including 2 fatalities resulting from falls. One staff member defrauding residents. Poor standard of care evidence by incidence of pressure ulcers; failure to report 4 pressure ulcer cases.
Williams, S., 2010	Mrs D N: 90+	Died at care home with nursing, but at care home up to two days prior to death	Range of serious health problems	Death because of natural causes – vascular disease. Pressure sores – indicated possible neglect; concern about decision to move her two days prior to death.
Winter, I., 2015	RC: 61, male	Supported accommodation	Moderate learning difficulty and bi-polar disorder	Death as a result of a choking incident. Pressure ulcers listed as a concern.