NHS
Bradford District Care
NHS Foundation Trust

Non-concordance guidance and flowchart for pressure ulcer prevention

Non-Concordance Guidance for Pressure Ulcer Prevention January 2020 – Jacqueline Knott/Sarah Horsfall

Non-concordance guidance for pressure ulcer prevention

Step 1: In all cases the following must be considered/carried out and documented	
A - Mental capacity assessment.	• All patients should be assumed to have capacity unless there is an impairment of the mind or brain which affects their ability to make specific decisions. • Assess the patient's capacity to make decisions about care using the mental capacity and decision-making tool which is available via the District Nursing Dashboard (Mental Health Act Policy and Procedures, 2015). • Ensure capacity assessments are time and decision specific and therefore may need to be repeated. • If patient is found to lack capacity (e.g. is not able to fully understand or discuss the decision to be made) the individual should be nursed in their best interests to prevent pressure ulcers. It may be necessary to undertake an MDT/Best Interests Meeting to explore how to best meet the needs of the patient at this stage. • If the patient has capacity, then they can make unwise decisions. • **All of the above should be clearly documented within the patient's clinical records on SystmOne and the relevant BDCFT DN risk assessment templates completed.**
B - Support understanding of the real risk of pressure ulceration.	• Ensure the patient/carers have a copy of the pressure ulcer information leaflet and explain the following: ▪ What a pressure ulcer is. ▪ How a pressure ulcer occurs. ▪ Why they are at risk. ▪ How severe a pressure ulcer can. become, leading to sepsis and death. • Advise the patient of the potential impact a pressure ulcer can have on their future health/quality of life The pressure ulcer information leaflet can be accessed here: PU Leaflet New Branded.docx (sharepoint.com)
Step 2: Non-concordance issue	**Care escalation**
A - Patient has declined a position change and/or skin inspection.	• Explain to the patient/carers that you wish to move them to check their skin condition and position them in a way that helps to offload pressure from parts of the body that are vulnerable to pressure damage. • Explore/ discuss reasons why patient does not wish to

	be moved referring to Appendix A. • Seek compromise: ask patient to try a position change for a short interval only e.g. 10 to15 minutes to see if it is comfortable. • Explain that it is necessary for staff to maintain subsequent re- offers of re-positioning/skin inspections, but staff will respect patient's wishes if they choose to decline some or all of the subsequent offers. • **Document within SystmOne why the patient does not wish to be repositioned/have skin inspections carried out and any conversations held/ or actions taken.**
B - Patient has declined use of a pressure redistributing device such as a specialist mattress/cushion /offloading device.	• Explain why the patient needs to use the device. • Explore/ discuss reasons why the patient does not wish to use the device referring to Appendix A. • **Document within SystmOne why the patient does not wish to use specialist equipment, the conversations held, and actions taken.**
C - Patient refuses to go to bed, choosing to sleep in the chair.	• Explain why sleeping in the bed is preferable. • Explore/discuss any reasons why the patient does not want to sleep in bed referring to Appendix A. • Ask the patient to agree to compromise e.g. spend some time in the chair with an agreed interval time in the bed. • **Document within SystmOne why the patient does not wish to sleep in bed, the conversations held, and actions taken.**

Step 3:

A - In all cases advise the patient that it is your duty to revisit this conversation with them at subsequent visits.

B - All patient non concordance must be referred to the Tissue Viability Service in line with Trust policy.

C - Consider the need to make a safeguarding referral when the patient's life is at risk as per the Trust's safeguarding adults policy.

D – Refer to Appendix A section 2 for additional points to consider.

Non-concordance flowchart for pressure ulcer prevention

Step 1: In all cases the following must be considered and/or carried out and documented.

A: Mental capacity assessment

B: Support understanding of the risk of pressure ulceration

STEP 2: Identify non-concordance issue
(This can be any combination of A, B and/or C below)

A: Patient has declined a skin inspection and/or position change

B: Patient has declined use of a pressure redistributing device such as a specialist mattress/cushion/offloading device

C: Patient refuses to go to bed, choosing to sleep in the chair

STEP 3: Overview of actions undertaken

A: In all cases advise the patient that it is your duty to revisit this conversation with them at subsequent visits

B: All patient non-concordance must be referred to the Tissue Viability Service in line with Trust policy

C: Consider the need to make a safeguarding referral when the patient's life is at risk as per the Trusts safeguarding policy

For further support and guidance within each step, please refer to: the non-concordance guidance for pressure ulcer prevention document and consider the supporting information in Appendix A.

Appendix A Section 1 – supporting information			
Care declined	**Possible reasons and what to look for:**	**What community staff nurse could consider:**	**Where to raise the concern:**
Declining position changes or refusal to move. **Declining skin inspections.**	**Uncontrolled Pain:** • Refusal to move/or to be assisted to move. • Nonverbal signs of pain – facial expressions. • Not interested in food or drink. • Disturbed sleep pattern or change in sleep pattern. • Acute physical illness.	**Uncontrolled Pain:** • Complete a pain assessment score and document this within SystmOne. • Check to see if adequate analgesia is prescribed, is being taken and effective. • If pain control is not effective to enable comfortable position changes, ask GP to review analgesia. • Check if moving and handling assessment remains appropriate. • Check if Kerrapro is indicated. • Check if Parafricta would help. • Check slide sheets are being used/in place/appropriate.	**Uncontrolled Pain:** • Senior carers. • GP. • DN Team. • Request medication review. • Discussion with family.
Non concordance with pressure relieving equipment. **Declining pressure relieving equipment.**	**Chair/wheelchair:** • Is the chair appropriate? – Is the patient/cushion slipping in the chair? • Is the chair too small or too large? • Is the cushion too deep or not deep enough?	**Chair/wheelchair:** • Check the position of the patient in the chair/wheelchair. • Discuss alternative device options with the patient. • Discuss alternative pressure re-distributing products with patient e.g. Kerrapro or Parafricta. • Consider pressure redistribution with smart use of pillows e.g. 30-degree tilt. • Consider photographs with consent to demonstrate problems identified .	**Chair/wheelchair** • Wheelchair services. • OT. • Physio. • Pressure Ulcer. Nurses (TV). • Discussion with family and carers.

Declining to go to bed. **Sleeping in the chair.**	**Not going to bed:** • Is the patient able to get into bed? • Is the bed accessible? • Does the bed compromise mobility at night?	**Not going to bed:** • Height of bed. • Type of mattress – is this compromising mobility? • Pain. • Urinary incontinence/frequency? • Fear of falling.	**Not going to bed:** • OT/Physio. • Pressure ulcer nurse. • Continence Service. • Falls team. • Discussion with family and carers.
Appendix A Section 2 – additional points to consider			
Dementia – disease progression.	• Change in ability to understand rationale for changing position/use of equipment/offload pressure areas/sleeping in the chair.	• Check MUST/MAELOR score. • Check swallowing as this will indicate disease progression. • Consider dementia review. • Consider GP review.	• DN team. • GP – SALT referral • Dietician. • Mental Health Team. • Discussion with family and carers.
Impact of long-term conditions.	• Is there a long-term condition that affects mobility or understanding? E.g. Rheumatism, Heart Failure, COPD, Arthritis, Lymphoedema, Stroke, Parkinson's, MS, Diabetes, PVS, Amputation, Contractions etc.	• Consider review of long-term condition. • Consider adaptations to aid mobility and communication.	• G.P • Nurse specialist. • Community matron. • Physio. • OT. • Pressure ulcer nurse (TV). • Discussion with family and carers.

Assess the 24-hour period.	• Take steps to understand the complete 24-hour period – when does the patient get up, where do they sit, activities, eating, drinking, toileting regimes, bed rest. • What happens on a night time? • What position does the patient sleep in? • Can the patient change own position?	• What support does the patient have and does this need increasing? • Are they any charts in place and are these completed accurately? • Does equipment require upgrading?	• GP. • TV/PU. • Physio. • OT. • Specialist nurses. • Discussion with family and carers.

References

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