Executive summary: Surrey Safeguarding Adults Protocol, Pressure Ulcers and the interface with a Safeguarding Enquiry

This protocol provides a framework to assist practitioners and managers across health and care organisations to provide high quality care and appropriate responses to individuals at risk of developing pressure ulcers. Prevention of pressure ulcers is not only ideal but, in most cases, perfectly possible. Taking a proactive approach will reduce harm to individuals and secure efficiencies to the wider health and social care system.

The aim of this protocol is to provide a local framework aligned to national guidance national, identifying pressure ulcers as primarily an issue for clinical investigation rather than a safeguarding enquiry led by the local authority. Where pressure ulcers do occur, this guidance offers a clear process for the clinical management of the removal and reduction of harm to the individual and the decision making process as to whether a safeguarding concern should be raised with Surrey Adult Social Care in order for them to decide if an adult safeguarding response under section 42 of the Care Act 2014 is necessary. Indicators to help decide when a pressure ulcer case may additionally need a safeguarding enquiry are included. Whilst the operational responsibility for investigating pressure ulcers is largely health led, Surrey Safeguarding Adult Board (SAB) has a strategic interest in the prevalence of pressure ulcers across the sectors as one indicator of quality of care.

This protocol should be applied to all pressure ulcers reported by anyone including care providers, clinicians, anyone undertaking safeguarding enquiries, unpaid carers, relatives and individuals themselves, as any tissue damage resulting from pressure should be considered. The previous definitions of either “avoidable” or “unavoidable” in relation to pressure ulcers is no longer used so all incidents of pressure ulcers will now be investigated in order to support organisational and system learning and ensure appropriate actions.

Where concerns are raised regarding skin damage as a result of pressure, there is a need to raise it as a safeguarding concern within each individual organisation. In a minority of cases it may warrant referring a safeguarding concern to Surrey Adult Social Care. An Adult Safeguarding Decision Guide assessment for service users with pressure ulcers should be completed by a qualified member of staff who is a practising Registered Nurse (RN), with experience in wound management and not directly involved in the provision of care to the service user. This does not have to be a Tissue Viability Nurse. The adult safeguarding decision guide should be completed immediately or within 48 hours of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension should be recorded.

The safeguarding decision guide assessment considers six key questions incorporating a safeguarding decision guide score. This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the pressure ulceration. It is not a tool to risk assess for the development of pressure damage. The threshold for raising a concern is 15 or above. However, this should not replace professional judgement.

Photographic evidence to support the report should be provided wherever possible. Consent for this should be sought as per local organisation policy but great sensitivity and care must be taken to protect the individual. Body maps must be used to record skin damage and can be used as evidence

if necessary at a later date. If two workers observed the skin damage they should both sign a body map.

The outcome of the Adult Safeguarding Decision Guide assessment should be documented on the Adult Safeguarding Decision Guide. If further advice/support is needed with regards to making the decision to raise a concern to the local authority, the Safeguarding Adults lead or the next most senior manager within the organisation should be contacted. However, if forty eight hours have passed without a clear decision, it should be referred to Surrey MASH for Adults as a safeguarding concern.

Where the score is 15 or higher, or where professional judgement determines safeguarding concerns, a copy of the completed decision guide, should be submitted to Surrey MASH for Adults along with the safeguarding referral: MASH Referral Form, Email: ascmash@surreycc.gov.uk . Copies of these forms should also be retained in the service users' electronic/paper notes. Where there is no indication that a safeguarding concern needs to be raised the completed decision guide should be retained in the service user's notes

Where the individual has been transferred into the care of the organisation it may not be possible to complete the decision guide. Contact should be made with the transferring organisation to ascertain if the decision guide has been completed or any other action taken. If a professional has concerns regarding poor practice, s/he must ensure appropriate escalation by raising it as a safeguarding concern within the organisation and a decision should be made whether to refer a safeguarding adults concern to Surrey Adult Social Care Surrey. The decision as to whether there should be a section 42 enquiry will be taken by the local authority, informed by a clinical view. A summary of the decision should be recorded and shared with all agencies involved.

Where an internal investigation is required, this should be completed by the organisation that is taking care of the individual, such as the District nurse team lead, ward manager or nursing home manager, in line with the local policies, such as pressure ulcer or risk management policies.
Surrey Adult Social Care needs to decide/agree post completion of the internal investigation if a full multi-agency meeting or virtual (telephone) meeting needs to be convened to agree findings, decide on safeguarding outcome and any actions.

It is believed that many pressure ulcers can be prevented when the right interventions are utilised and could be avoided through simple actions by staff, individuals and their carers. As well as causing long-term pain and distress for individuals, treatment is estimated to cost the NHS between £1.4 and £2.1 billion per year. There is a good strong evidence base on how to prevent pressure ulcers from developing. There is a greater need to share and heed this evidence base and take action if we are to reduce the incidence of this avoidable harm. Pressure ulcers are a key indicator of the quality of nursing care. Preventing them happening will improve all care for patients.

Surrey Safeguarding Adults Board Pressure Ulcer Protocol

Guidance for completing the adult safeguarding

Adult Safeguarding Decision Guide for individuals with severe pressure ulcers

29 November 2019