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

29 November 2019

Contents

1. Introduction

1.1 This protocol will provide 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.

1.2 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 the local authority in order for them to decide if an adult safeguarding response under section 42 of the Care Act 2014 is necessary. The guidance demonstrates that the focus on removing harm to the individual will usually be secured by speedy clinical intervention

1.3 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.

1.4 This protocol has been developed and agreed in the broader context of the implementation of the Care Act 2014 and the drive towards greater integration between the health and social care systems. The core principle underpinning the Care Act is promoting individuals’ well-being.

1.5 Those at risk of pressure ulcers are cared for in many different settings across health and social care, including their own home. Terminology used in these settings may vary, the term patient, resident, service user, and clients are all often used. For the purpose of this guidance the term individual or person will be used throughout. A helpful beginning point is the principle of well-being. As it states in the Care and Support statutory guidance ‘Wellbeing’ is a broad concept and it is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect)
- Physical and mental health and emotional wellbeing
- Protection from abuse and neglect control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- Participation in work, education, training or recreation
- Social and economic wellbeing

- Domestic, family and personal
- Suitability of living accommodation
- The individual's contribution to society

1.6 This principle requires all agencies to work together to achieve the best outcomes for the individual. The Care Act clearly lays out the duties of relevant partners to cooperate including, but not only, local authorities and NHS bodies. This requires a shift of approach from one dominated by processes and tick boxes to a person-centred model that begins with the person at the centre of the concerns and fully involves them or their representative as appropriate. The response to the presence of pressure ulcers should involve the individual and their family, explaining the concerns and seeking their views.

1.7 It is believed 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.

2. Aim

2.1 The aim of this protocol is to provide a local framework aligned to national guidance, identifying pressure ulcers as primarily an issue for clinical investigation rather than a safeguarding enquiry led by the local authority. 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, Safeguarding Adult Boards (SABs) have a strategic interest in the prevalence of pressure ulcers across the sectors as one indicator of quality of care.

2.2 Where a pressure ulcer is one of a number of safeguarding concerns in relation to an individual or setting then there should be a multi-agency approach coordinated by the local authority, with health taking the lead for the clinical investigation.

3. Scope

3.1 The Care Act 2014 states clearly that concerns about the quality of a service provided are not automatically safeguarding concerns under section 42 of the Act.

3.2 Safeguarding is about protecting an individual's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risk and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

3.3 Safeguarding Adults is used to describe all work to help adults with care and support needs stay safe from abuse and neglect. It replaces the term "adult protection". The term "adult at risk of abuse and neglect" has been used to replace "vulnerable adult", (DoH, 2000). This is because the term "vulnerable adult" may wrongly imply that some of the reason for the abuse lies with the adult abused and also assumes that the simple case of being old or having a disability renders one vulnerable and this is not the case. Other factors such as social isolation, lack of circles of support and unsuitable accommodation can be pivotal. An adult at risk may therefore be a person who,

• is old and frail due to ill health, physical disability or cognitive impairment;

• has a learning disability;

• has a physical disability and/or a sensory impairment,

• has mental health needs including dementia or a personality disorder;

• has a long term illness/condition;

• misuses substances or alcohol;

• is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse;

• is unable to demonstrate the capacity to make a decision and is need of care and support

4. Background

4.1 Pressure ulcers may occur as a result of neglect. Neglect may involve the deliberate withholding OR unintentional failure of a paid, or unpaid, carer to provide appropriate and adequate care and support. Neglect and acts of omission include ignoring medical, emotional or physical care needs, failure to provide access to appropriate health care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating. In some instances this is highly likely to result in, significant preventable skin damage. Where unintentional neglect may be due to an unpaid carer struggling to provide care an appropriate response would be to revise the package of care and ensure that the carer has the support and equipment to care safely.

4.2 Skin damage has a number of causes, pressure ulcers are caused by sustained pressure, including pressure associated with shear, where the person's individual tissue tolerance and susceptibility to pressure has been overcome. External shear forces occur due to movement of the skin surface relative to a supporting surface, such as when an individual slides down the bed when in a semi-recumbent sitting position. This results in distortion of the soft tissue layers, including the blood vessels. Shear commonly occurs at the sacrum and heels. Internal shear forces can occur within the soft tissue layers due to both compression and shear forces. Some causes of skin damage relate to the individual person, including factors such as the person's medical condition, nutrition and hydration. External factors including poor care, poor communication between carers and nurses, ineffective multi-disciplinary team working or a lack of access to appropriate resources such as equipment and staffing may contribute to this.

4.3 When advising an individual who has capacity, about self-care and prevention of pressure ulcers, it is important to establish that the person has understood the advice, can put the advice into practice, has any necessary equipment, knows how to use it and understands the implications of not following the advice. Where it appears that the individual is neglectful in caring for themselves or the environment, staff should seek further advice. It is recognised that not all pressure ulcers can be prevented and the risk factors for each person should be looked at on an individual basis and an appropriate care plan put in place that is regularly and frequently reviewed.

5. Definitions

5.1 Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.

5.2 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.

5.3 If a professional has concerns regarding poor practice, s/he must ensure appropriate escalation by reporting all pressure ulcers via the serious incident internal reporting mechanisms within their organisation. All pressure ulcers should be investigated and a safeguarding concern should be referred to the local authority if there is reasonable cause to suspect the adult has experienced, or is at risk of, abuse or neglect, from which they are unable to protect themselves due to their care and support needs. The Local Authority can then make a decision around further action as appropriate under section 42 of the Care Act 2014 is necessary.

5.4 An 'old' pressure ulcer is defined as being a pressure ulcer that was present when the patient came under your care, or developed within 72 hours of admission to your organisation.

5.5 A 'new' pressure ulcer is defined as being a pressure ulcer that developed 72 hours or more after the patient was admitted to your organisation. To assess skin damage, you should examine the patient for any skin damage and ask them about any skin damage they have experienced as well as consulting their notes or handover documents.

5.6 Category of the pressure ulcer

The category is based on the European Pressure Ulcer Scale:

i. None: No pressure ulcer, or a pressure ulcer that is deemed less severe than a Category 2.

ii. Category 2: Partial thickness skin loss or blister. Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

iii. Category 3: Full thickness (fat visible). Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Some slough may be present. May include undermining and tunnelling.

iv. Category 4: Full thickness loss (bone visible). Full thickness tissue loss with exposed bone, tendon or muscle. Slough or Eschar may be present. Often includes undermining and tunnelling.

5.7 Cases of single category/grade 1 and 2 pressure ulcers must be considered as requiring early intervention to prevent further deterioration of damage.

5.8 Severe damage in the case of pressure ulcers is indicated by multiple pressure ulcers of category/grade 2 or a single category/grade 3 or 4 (to include unstageable and suspected deep tissue injury). It is recognised that severe pressure ulcer damage can already be present and yet not visible on the skin. These are known as incipient pressure ulcers

5.9 All levels of skin damage as a result of pressure or shear, or a combination of both, must be reported through the serious incident process.

5.10 A lesion that has been determined as combined, that is, caused by both moisture and pressure, must be recorded in the notes as a pressure ulcer.

5.11 Skin damage that is determined to be as a result of pressure from a device, such as from casts or ventilator tubing and masks must be recorded as pressure damage. These are known as device related pressure ulcers (EPUAP, 2014).

6. Safeguarding Concern Assessment Guidance

6.1 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 raising a safeguarding concern with the local authority.

6.2 A history of the development of the skin damage should first be obtained by a clinician, usually a nurse. If the person's care has recently been transferred, this may require contact being made with former care providers for information, to seek clarification about the cause and timing of the skin damage. This is the responsibility of the organisation raising the concern.

6.3 Where there is concern that pressure ulceration has occurred, the practitioner should, in discussion with individual and family, refer the individual to the appropriate local healthcare services, unless they are already in receipt of such services, even where they are in receipt of social care services.

6.4 An Adult Safeguarding Decision Guide assessment for service users with pressure ulcers (Appendix 3) 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.

6.5 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. For example, this might be an Executive Nurse in a health setting. However, if forty eight hours have passed without a clear decision, it should be referred to Surrey MASH for Adults as a safeguarding concern.

6.6 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.

6.7 Following this, a decision should be made whether to refer a safeguarding adults concern to the local authority, in line with agreed local arrangements.

6.8 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.

6.9 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.

6.10 The local authority 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.

6.11 The safeguarding decision guide assessment considers six key questions: The six questions shown below together indicate 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.

6.12 The threshold for raising a concern is 15 or above. However, this should not replace professional judgement. The questions and scores are outlined in Appendices 1, 2 and 3 which provide the full decision making tool and recording document.

(i) Has the patient or service user's skin deteriorated to either category 3/4/unstageable or multiple sites of category 2 ulceration from healthy unbroken skin since the last opportunity to assess/visit?

(ii) Has there been a recent change in their clinical condition that could have contributed to skin damage? E.g. infection, pyrexia, anaemia, end of life care (Skin Changes at Life End), critical illness?

(iii) Was there a pressure ulcer risk assessment and reassessment with an appropriate pressure ulcer care plan in place and was this documented in line with the organisation's policy and guidance?

(iv) Is there a concern that the pressure ulcer developed as a result of the informal carer ignoring or preventing access to care or services?

(v) Is the level of damage to skin inconsistent with the service user's risk status for pressure ulcer development? E.g. low risk–category/ grade 3 or 4 pressure ulcer?

(vi). Answer **(a)** if the individual has capacity to consent to every element of the care plan – Was the individual able to implement the care plan having received clear information regarding the risks of not doing so?

Answer **(b)** if the individual has been assessed as not having mental capacity to consent to any or some of the care plan - Was appropriate care undertaken in the individual's best interests, following the best interests checklist in the Mental Capacity Act Code of Practice (supported by documentation, e.g. capacity and best interest statements and record of care delivered)?

• Is there evidence that the person, or their representative, was involved with the care and support planning, and did they consent to the care plan?

• Is there evidence that this involvement was reviewed if care needs changed, and the current care plan would meet the needs of the person?

• Is there evidence that if the person was not consenting to the care plan that other remedial actions were considered to mitigate risk of harm?

• If at the point of the care plan being put in place it was identified that the person lacked capacity to consent to it, was the care plan lawfully put in place in their best interest?

6.13 Photographic evidence to support the report should be provided wherever possible. Consent for this should be sought as per local policy but great sensitivity and care must be taken to protect the individual. Body maps (see Appendix 4) 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.

6.14 Documentation of the pressure ulcer should include site, size – including its max length, width and depth (centimetres) and category/grade.

6.15 The assessment should be recorded using the Adult Safeguarding Decision Guide assessment.

6.16 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. Copies of both should also be retained in the service users' electronic/paper notes.

6.17 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.

Appendix 1: Guidance for completing the adult safeguarding decision guide

History

• Include any factors associated with the person's behaviour that should be taken into consideration e.g. sleeping in a chair rather than a bed

Medical History

• Does the person have a long term condition or take any medication which may impact on skin integrity; for example Rheumatoid Arthritis, COPD, chronic oedema or steroid use.

• Is the person receiving end of life care?

• Does the person have any mental health problems or cognitive impairment which might impact on skin integrity? E.g. dementia / depression

Monitoring of skin integrity

• Were there any barriers to monitoring or providing care e.g. access or domestic/social arrangements

• Should the illness, behaviour or disability of the person have reasonably required the monitoring of their skin integrity (where no monitoring has taken place prior to skin damage occurring)?

• Did the person decline monitoring? If so, did the person have the mental capacity to decline such monitoring?

• Were any further measures taken to assist understanding e.g. patient/service user information, leaflets given, escalation to clinical specialist, ward leads, team leader, and senior nurses?

• If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?

• Were there any other notable personal or social factors which have affected the person's needs being met? E.g. history of self-neglect, lifestyle choices and patterns, substance misuse, unstable housing, faith, mental ill health, learning disability

Expert advice on skin integrity

• Was appropriate assistance sought? E.g. professional advice from a Community Nurse, Clinical Lead or Tissue Viability Specialist Nurse

• Was advice provided? If so was it followed?

Care planning & implementation for management of skin integrity

• Was a pressure ulcer risk assessment carried out upon entry into the service and reviewed at appropriate intervals?

• If expert advice was provided did this inform the care plan?

• Did skin integrity assessment and monitoring at suitable and appropriate intervals form part of the care plan?

• Were all of the actions on the care plan implemented? If not, what were the reasons for not adhering to the care plan? Were these documented?

• NB: If the person has been assessed as lacking mental capacity to consent to the care plan, has a best interest decision been made and care delivered in their best interests?

• Did the care plan include provision of specialist equipment?

Was the specialist equipment used appropriately?

• Was the care plan revised within time scales agreed locally?

Care provided in general (hygiene, continence, hydration, nutrition, medications)

• Does the person have continence problems? If so, are they being managed? Are skin hygiene needs being met? (Including hair, nails and shaving)? Has there been deterioration in physical appearance?

• Are oral health care needs being met?

• Does the person look emaciated or dehydrated?

• Is there evidence of intake monitoring (food and fluids)?

• Has the person lost weight recently? If so, is person's weight being monitored?

• Are they receiving sedation? If so, is the frequency and level of sedation appropriate?

• Do they have pain? If so, has it been assessed? Is it being managed appropriately?

Other possible contributory factors

• Has there been a recent change (or changes) in care setting?

• Is there a history of falls? If so, has this caused skin damage? Has the person been on the floor for extended periods?

Appendix 2: Decision Process

1. Concern is raised that a person has severe pressure damage Category/grade 3, 4, unstageable, suspected deep tissue injury or multiple sites of category/ grade 2 damage (EPUAP, 2014)

2. Complete adult safeguarding decision guide and raise an incident immediately as per organisation policy.

Score 15 or higher? Concern for safeguarding

IF YES:

Discuss with the person, family and/ or carers, that there are safeguarding concerns and explain reason for treating as a concern for a safeguarding enquiry has been raised.

1. Refer to Surrey Adult Social Care via local procedure (see Appendix 6) with completed safeguarding pressure ulcer decision guide documentation.

2. Follow local pressure ulcer reporting and investigating processes.

3. **Record decision in person's records.**

IF NO

Discuss with the person, family and/ or carers, and explain reason why not treating as a safeguarding enquiry.

Explain why it does not meet criteria for raising a safeguarding concern with the Local Authority, but then emphasis the actions which will be taken.

1. Action any other recommendations identified and put preventative/ management measures in place.

2. Follow local pressure ulcer reporting and investigating processes.

3. Record decision in person's records.

Appendix 3: Adult Safeguarding Decision Guide for individuals with severe pressure ulcers

Q	Risk Category	Level of Concern	Score	Evidence
1	Has the patient's skin deteriorated to either grade 3/4/ unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/ visit	Yes e.g. record of blanching / non-blanching erythema /grade 2 progressing to grade 2 or more	5	E.g. evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
		No e.g. no previous skin integrity issues or no previous contact health or social care services	0	
2	Has there been a recent change, I.e. within days or hours, in their / clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anaemia, end of life care, critical illness	Change in condition contributing to skin damage	0	
		No change in condition that could contribute to skin damage	5	
3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	0	State date of assessment Risk tool used Score / Risk level
		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	What elements of care plan are in place

		No or incomplete risk assessment and/or care plan carried out	15	What elements would have been expected to be in place but were not
4	Is there a concern that the Pressure Ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services	No / Not applicable	0	
		Yes	15	
5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk–Category/ grade 3 or 4 pressure ulcer	Skin damage less severe than patient's risk assessment suggests is proportional	0	
		Skin damage more severe than patient's risk assessment suggests is proportional	10	
6	Answer (a) if your patient has capacity to consent to every element of the care plan. Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan.			
a	Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Patient has not followed care plan and local non concordance policies have been followed.	0	
		Patient followed some aspects of care plan but not all	3	

		Patient followed care plan or not given information to enable them to make an informed choice.	5	
b	Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice? (supported by documentation, e.g. capacity and best interest statements and record of care delivered)	Documentation of care being undertaken in patient's best interests	0	
		No documentation of care being undertaken in patient's best interests	10	
TOTAL SCORE				

If the score is 15 or over, discuss with the local authority (safeguarding) as determined by local procedures and reflecting the urgency of the situation. When the decision guide has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the patient's notes

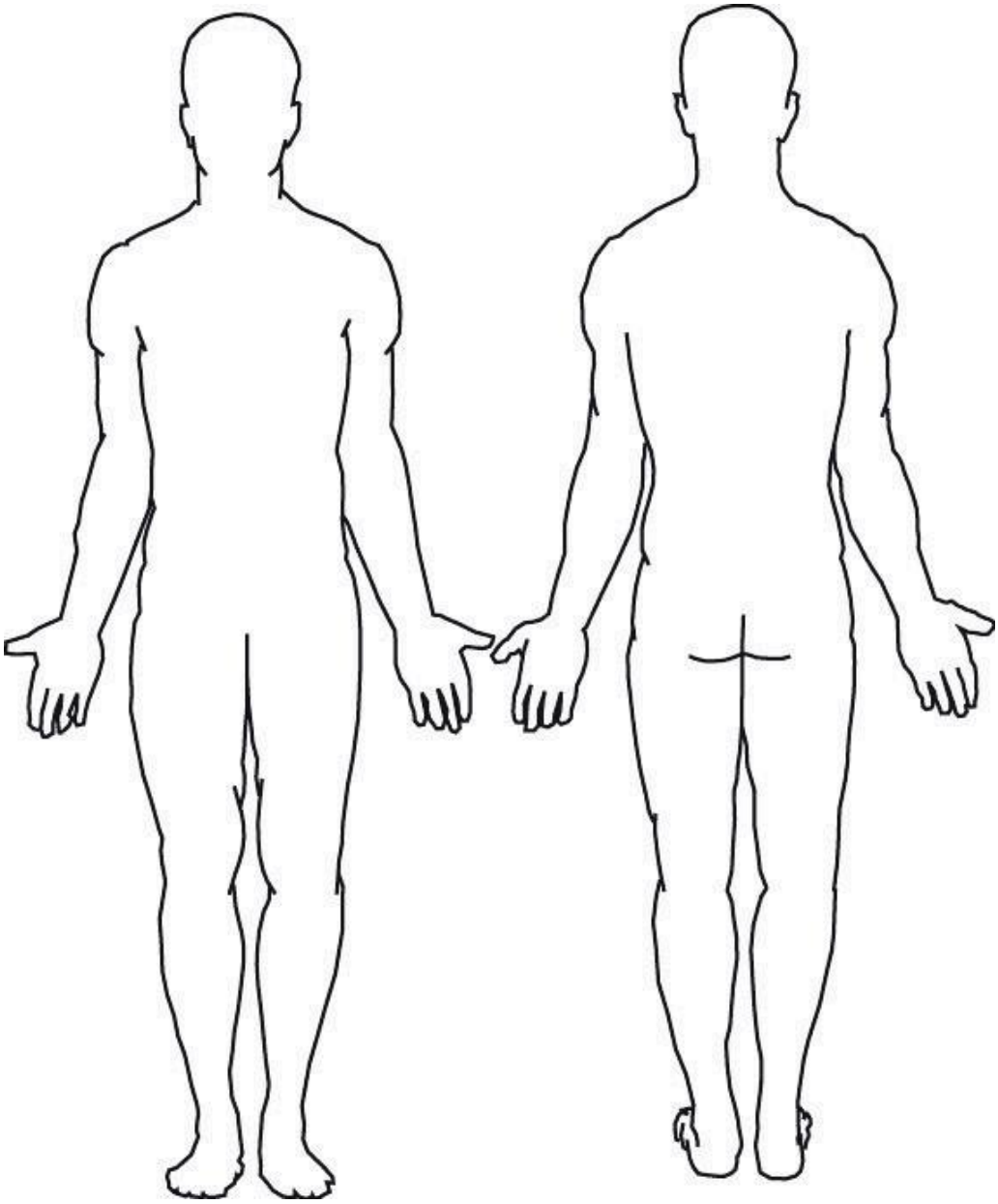
Patient Name: ……

Patient No:……..…

Name of assessing nurse (PRINT)			
Job Title		Signature	
Name of second assessor (PRINT)			
Job Title		Signature	

Appendix 4: Body Map

Body maps should be used to record skin damage and can be applied as evidence if necessary at a later date. If two workers observed the skin damage they should both sign the body map.



Name of assessing nurse (PRINT)			
Job Title		Signature	
Name of second assessor (PRINT)			
Job Title		Signature	

Patient Name: ……

Patient No:……..…

Appendix 5: Adult Safeguarding concern proforma regarding pressure ulceration

Details of individual with pressure ulcer(s)			
First name		Last name	
D.O.B		NHS Number	
Persons completing decision guide for safeguarding concern			
Department/Base /Address		Organisation Name	
		Telephone Number	
Name of assessing nurse (PRINT)			
Job Title		Signature	
Name of second assessor (PRINT)			
Job Title		Signature	
Date and Time assessors witnessed pressure ulceration		Date / time of completing documentation/Concern	

Appendix 6: Referral pathway for Surrey

If someone is in immediate danger, contact the emergency services on 999. If someone is not in immediate danger but you need help fast, contact the police on 101.

Surrey MASH for Adults:

During office hours

Tel: 0300 470 9100

Email: ascmash@surreycc.gov.uk

Or complete the MASH Referral Form and email to Adults MASH

Out of hours
Call the Adult Social Care Emergency Duty Team on: 01483 517898

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