NHS
Haringey
Clinical Commissioning Group

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Safeguarding Adults Pressure Ulcer Protocol: Deciding whether to do a Safeguarding Adult referral.

Safeguarding Adults and Pressure Ulcer Protocol: Deciding whether to refer to the Safeguarding Adults Procedures

To date the government has advised that anyone who develops category 3, category 4 or un-gradable pressure ulcers be referred as a safeguarding risk. The analysis of the referrals has shown that only about 20% of all referrals go on to require investigation. The documentation required to report someone as a possible safeguarding risk is lengthy so this decision making tool has been developed to ensure only people who do require investigation are reported. Using this tool will ensure it will only be necessary to complete a safeguarding alert if the tool shows the person is deemed at risk of abuse.

What is Safeguarding?

The government's statement on safeguarding advises that everyone has a responsibility, including the general public, to safeguard people against poor practice, harm and abuse. It is the providers' core responsibility, across health and social care, to provide safe, effective and high quality care. This decision making tool assists a provider in deciding if the person has developed a pressure ulcer as a result of neglect or abuse.

Safeguarding Adults and Pressure Ulcer Protocol updated following Department of Health and Social Care: Safeguarding Adults Protocol – Pressure Ulcers and the interface with a Safeguarding Enquiry January 2018 – Please refer to full guidance document https://www.gov.uk/government/publications/pressure-ulcers-safeguarding-adults-protocol) which gives further details of the aim, scope, definitions and impact of this protocol.

Introduction

This protocol will provide a framework for health and care organisations to draw on when developing guidance for staff in all sectors and agencies that may see a pressure ulcer. If the staff member is concerned that the pressure ulcer may have arisen as a result of poor practice, neglect/abuse or an act of omission, the local guidance should be clear about what steps they need to take and whether the local authority safeguarding duties are triggered.

From a governance perspective, each organisation that utilises this protocol will be responsible for ensuring that local guidance reflects the protocol is used appropriately and that is use monitored. Safeguarding Adult Boards (SABs) and Quality Surveillance Groups (QSGs) will want to be reassured that this is the case.

This protocol should be applied to 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.

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.

The imperative for this protocol derived from the increasing concern across the sector about the prevalence of pressure ulcers, in all settings, and a lack of consensus about how investigating pressure ulcers should interface, or not, with local authority safeguarding duties as set out in the Care Act 2014 and the accompanying statutory guidance.[1]

Practice in some places does not promote individuals' well-being and threatens to overwhelm the local authority adult safeguarding system. There has been no previous

[1] 1.https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1, Paragraphs 14.10, 14.11 and 14.12

national standard protocol advising and supporting organisations in regard to pressure ulcers or the decision making process as to whether a safeguarding concern should be raised with the local authority in order for them to decide if a section 42 safeguarding enquiry is required.
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[2]
'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

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.

Several organisations including the Department of Health, Care Quality Commission, NHS England, Association of Directors of Adult Social Services and Health Education England have worked with the Tissue Viability Society, to review current guidance and practice in relation to pressure ulcers and safeguarding. Following a request to share information, several health trusts, listed at the end of this document, have submitted their local protocols for review. These have contributed to the discussions resulting in this protocol.

Background

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. In these circumstances it can be highly distressing to talk to carers about abuse and neglect, particularly where they have been

[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance paragraph

dedicated in providing care but have not been given advice and support to prevent pressure ulcers.
Skin damage has a number of causes, pressure ulcers are caused by sustained pressure, including pressure associated with shear[3] 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.
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.

1. Aim of Protocol and Introduction

1.1. The government's statement on safeguarding (2013) advises that distinctions need to be drawn between where there are concerns about the quality of the service provided and where there are safeguarding concerns.[4]

1.2. This is a multi-agency protocol including decision guide which aims to support decisions about appropriate responses to pressure ulcer care and whether concerns need to be referred into the local authority as a safeguarding alert.

1.3. The protocol provides guidance for staff[5] in all sectors who are concerned that a pressure ulcer may have arisen as a result of poor practice, neglect/abuse or act of omission and therefore have to decide whether to make a referral via the Pan London policy and procedures[6]. A flow diagram outlining the key elements of the protocol can be found in Appendix 1.

1.4. From a governance perspective each organisation will be responsible for ensuring that the protocol is used appropriately along with monitoring and reviewing its use.

1.5. Neglect is a form of abuse which involves the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support, where this has resulted in, or is highly likely to result in, significant preventable skin damage.

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[3] Shear is an applied force that tends to cause an opposite but parallel sliding motion of the planes of an object. Such motions cause tissues and blood vessels to move in such a way that blood flow may be interrupted, placing the patient at risk of pressure ulcers. An example of a shearing force is seen when a patient slumps in a chair, the skin around the buttocks is stretched by the movement and interferes with circulation. (Medical Dictionary 2015)
4.Statement of Government Policy on Adult Safeguarding May 2013
[5]The term staff is used to refer to employees from all sectors.
[6]Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse – SCIE report 39-2011

1.6. Skin damage has a number of causes, some relating to the individual person, such as poor medical condition and others relating to external factors such as poor care, ineffective multi-disciplinary team working, lack of appropriate resources, including equipment and staffing. **It is recognised that not all skin damage can be prevented and therefore the risk factors in each case should be reviewed on an individual basis before a safeguarding referral is considered**. All cases of actual or suspected neglect should be referred through the safeguarding procedures via Haringey Safeguarding Adults reporting process. This can be done by filling out a referral form. Click on the link to open referral form. http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults#whocanhelp or via telephone by calling Haringey Integrated Access Team (IAT)

1.7. Haringey Integrated Access Team (IAT) Contact details:

By email to: iat@haringey.gov.uk
By telephone to : 020 8489 1400: 24hrs services 7days a week
By FAX to: 020 8489 4900
By SMS: text IAT to 80818

1.8. ***All pressure ulcers must be considered as requiring early intervention to prevent further damage. If there are concerns regarding poor practice, an appropriate escalation must be considered, i.e. raising a clinical incident.***

1.9. The person should have a safeguarding referral made to Haringey Social Services if there is:

- Significant/Severe skin damage i.e. single category/grade 3 or category/grade 4, ulceration or multiple category/grade 2 pressure ulcers (to include unstageable and suspected deep tissue injury). There are reasonable grounds to suspect that it was preventable or
- Inadequate measures taken to prevent the development of pressure ulcer[7], or
- Inadequate evidence to demonstrate the above

1.10. Significant/Severe damage in the case of a pressure ulcer is indicated by multiple pressure ulcers of category/grade 2 or a category/grade 3 or category/grade 4 (to include unstageable and suspected deep tissue injury), as defined by the European Pressure Ulcer Advisory Panel (EPUAP, NPUAP, PPPIA, 2014) classification system. http://www.epuap.org/wp-content/uploads/2010/10/NPUAP-EPUAP-PPPIA-Quick-Reference-Guide-2014-DIGITAL.pdf

1.11. This protocol should be applied to pressure ulcers reported by anyone including carers, relatives and patients, as any tissue damage no matter who reports it should be investigated

1.12. Where concerns are raised regarding skin damage there is a need to decide if a safeguarding referral is required in addition to the clinical incident form. This includes history taking, contacting former care providers for information if the person's care has recently been transferred, and seeks clarification about the cause of the damage.

[7] With reference to the NICE guideline 29 and local policies

NHS Arrangements

1.13. Any category 2 and above pressure ulcer MUST be reported as a clinical incident according to local clinical governance procedures.

Should pressure ulcers be reported as Serious Incidents? From the NHS England Serious Incident Framework 2015/16 – frequently asked questions

1.14 Where the definition of a Serious Incident is met, the incident should be reported and investigated according to the principles set out in the Serious Incident Framework.
Often organisations report all category 3 and category 4 pressure ulcers as Serious Incidents. Clearly some will meet the definition but categorising all category 3 and category 4 pressure ulcers as Serious Incidents may lead to a 'burden of investigation that makes it difficult to move forward quickly and implement learning[8]'. **Consideration must be given to the circumstances of each case since the category of a pressure ulcer does not always indicate the severity of the wound.** For example, an infected category 2 pressure ulcer may lead to septicaemia and death whereas a very small category 3 pressure ulcer on the ear (designated as category 3 because cartilage will be exposed with any loss of overlying skin) may not have serious consequences for the patient.

1.15 Grading pressure ulcers can also be difficult, particularly when differentiating between a category 2 and category 3 pressure ulcer and also between a category 3 and category 4. **This is another reason why grading alone should not be relied on for determining overall severity**.

1.16 **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. It is not acceptable to locally define, in advance, certain types of pressure ulcer that are 'unavoidable' as long as some routine preventative measures have been undertaken. Any Serious Incident investigation which seeks to conclude that an incident was either 'avoidable' or 'unavoidable' rather than focusing what could be learned to prevent future harm is not compliant with Root Cause Analysis (RCA) methodology.

Haringey CCG Incident & Serious Incident Policy/Procedure

Pressure Ulcer Safeguarding Decisions

1.17 Initial Safeguarding decisions On identification of either a single category/grade 3 or category/grade 4 or multiple category/grade 2 pressure ulcers (to include unstageable and suspected deep tissue injury), if there are any immediate concerns/risks of abuse or neglect then a safeguarding referral will need be made immediately. If there are no immediate concerns, then the SAPU Deciding whether to do a safeguarding referral decision guide' (HCCG, 2015) should be applied within 24 hours. If the score is 15 or above (i.e. the PU is avoidable) then a safeguarding referral needs to be made, STEIS notification completed and a root cause analysis (RCA) undertaken.

8 Tissue Viability Society, 2012, Achieving Consensus in Pressure Ulcer Reporting. Available online at: http://tvs.org.uk/wp-content/uploads/2013/05/TVSConsensusPUReporting.pdf

1.17 Safeguarding decisions need to be made at the following stages of investigation: i) if there are immediate concerns on identification of a pressure ulcer ii) following completion of the 'Safeguarding Adults Pressure Ulcer (SAPU) Deciding whether to do a safeguarding referral decision guide' (HCCG, 2015) and iii) following completion of a root cause analysis investigation (RCA) the SAPU decision guide will need to be applied again.
All multiple category/grade 2 or a single category/grade 3 or category/grade 4 pressure ulcers (to include unstageable and suspected deep tissue injury) will require an RCA to be completed within 10 working days. At the end of the RCA the SAPU decision guide (HCCG, 2015) will need to be applied. If the score is 15 or above (i.e. the pressure ulcer is avoidable) then a safeguarding referral should be made and STEIS notification completed. Any Serious Incident (SI) investigation that meets the criteria for SI reporting needs to be completed within 60 days of the incident occurring.

Definitions

1.18 *Unavoidable Pressure Ulcer*: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence." Unavoidable PUs do NOT need to be reported on STEIS

1.19 *Avoidable Pressure Ulcer*: "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate." Avoidable PUs DO need a STEIS notification AND Safeguarding referral.
[National Patient Safety Agency (2010) *Defining avoidable and unavoidable pressure ulcers.*
http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/PressureUlcers/Defining%20avoidable%20and%20unavoidable%20pressure%20ulcers.pdf (last accessed march 2012]

Increasingly care for even very frail people is delivered at home. Commissioners need to commission with this in mind, making explicit the need to prevent pressure ulcers and that staff delivering care should be trained in the prevention and treatment of pressure ulcers.

1.20 Incipient pressure ulcers as recognised:

> "Patients admitted or transferred to a healthcare setting without any obvious signs or symptoms of pressure area skin damage, the development of a pressure ulcer grade 3 or 4 within 72 hours is likely to be related to pre-existing damage incurred prior to admission or transfer of care. For any pressure area damage arising thereafter, the most likely cause will be related to care within the healthcare setting the patient is/are in; this must be regarded as a new event." (Reference: Nurse Sensitive outcome indicators for NHS provided care. Version 2, March 2010, NHS London)

All hospitals and community care organisations should body map all patients before transfers, on sending or receiving a patient from another organisation within 6 hours.

1.21 All levels of skin damage as a result of pressure or shear, or a combination of both, must be reported through well-understood local reporting systems that have been agreed by all partners and endorsed by the SAB and QSG.

1.22 Skin damage that is established to be as a result of incontinence and/or moisture alone, should not be recorded in the notes as a pressure ulcer but should be referred to as a moisture lesion to distinguish it, and recorded separately. However, where this might be as a result of neglect or poor oversight it should be explored not ignored.

1.23 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.

1.24 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).

1.25 Therefore any multiple pressure ulcers of category/grade 2 or a single category/grade 3 or category/grade 4 (to include unstageable and suspected deep tissue injury), identified within 72 hours of admission must be escalated and reported to the previous care provider as a clinical incidence. The 72 hour rule must be acknowledged and used as a guide, however it must be acknowledged a pressure ulcer can develop within a few hours.

1.26 Staff should also refer to:

- Their own organisation's policies and procedures on pressure ulcers
- Other relevant local and national guidelines, protocols and policies e.g. NICE Guidance, incident reporting policies.

1.27 There will be a process for ensuring the validity of the safeguarding decision guide protocol in accurately reporting a safeguarding risk.

A Safeguarding Quality Assurance Panel will meet once a month. The Terms of reference will be to review a percentage of the patients who have been assessed using the protocol. This will include referrals who were deemed a safeguarding risk and those who were not. This will show how effective the protocol is over a period of time. This Panel will also take a random selection from the Strategic Executive Information System (STEIS) to ascertain whether the safeguarding process has been followed.

2 Assessment Guidance

2.1 This is a multi- agency protocol which provides guidance for staff [9] who are concerned that a pressure ulcer may have arisen as a result of poor practice or neglect/abuse. The following provides guidance about when to refer as a safeguarding concern. In a minority of cases it may warrant raising a safeguarding concern with the local authority.

2.2 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.

2.3 Where there is concern that pressure ulceration has occurred, the practitioner should, in discussion with individual and family, refer the individual to the

9 The term staff is used to refer to employees from all sectors.

appropriate local healthcare services, unless they are already in receipt of such services, even where they are in receipt of social care services.

2.4 An Adult Safeguarding Decision Guide assessment for service users with pressure ulcers (Appendix 5) 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 24 hours of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension should be recorded.

2.5 Assessment of the wound and completion of the decision guide must be completed by a qualified member of staff who is a practicing registered nurse (RN) or GP with experience in pressure ulcer prevention and management and not directly involved in the provision of care to the service user. If the pressure ulcer is found within a non- clinical setting such as a residential care home or the person's own home and is not currently being treated, a referral should be made by an appropriate health professional to review the wound e.g. General Practitioner or District Nurse as detailed in the organisation's pressure ulcer prevention and management policy. A copy of the following should be sent:

- **Anonymised** Safeguarding Adult referral
- **Anonymised** Copy of **ALL** Completed Protocol Decision Guides

to: Haringey Clinical Commissioning Group via the following email address: pressureulcerprotocol@nhs.net Clinical settings are defined as: Hospitals; Mental Health Hospitals and Nursing Care Homes.

2.6 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.

2.7 The practitioner who raises the concern should ensure that they speak with their line manager or an individual who is in a senior position e.g. Care Home Manager, Matron, GP, Social Worker or Care Homes Support Team Specialist Nurse. They may or may not be directly involved in the patient's care. Their role is to contribute to the assessment process and verify that procedures have been carried out correctly. This outcome of the decision guide must be documented on the report form in Appendix 4.

2.8 Where the patient has been transferred into the care of an organisation it may not be possible to complete the decision guide. Contact should be made with the transferring organisation to ascertain if a safeguarding alert has been raised or the decision guide has been completed; if neither then an alert should be raised.

2.9 The safeguarding decision guide should be completed immediately or within **24 hours** of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension must be documented (Appendix 4).

2.10 Following this, a decision should be made whether to make a safeguarding referral to Social Services/ the local authority, in line with agreed local arrangements. For patients who score less than 15 on the decision making tool (Appendix 5) a safeguarding referral will not be required, however, patients who

score 15 and above, this should be automatically referred. It should be noted that the score does not preclude clinical judgement. If the assessor feels there is an element of doubt then the patient should be referred to safeguarding even if the score is below 15.

2.11 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.

2.12 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.

2.13 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.

2.14 The decision as to whether there should be a full investigation is made at the multi-agency Safeguarding Adults Strategy Meeting. The strategy meetings are convened in response to individual cases. A summary of the strategy discussion should be recorded and shared with all agencies involved.

2.15 The strategy meeting discussion will consider the Safeguarding referral and the 24 hour serious incident notification report and whether further information is required by the author. If it is decided to continue to the safeguarding process the strategy meeting will decide the type and time frame for completion of the investigation needed i.e. safeguarding investigation, serious incident investigation or a combination of both. The serious incident investigation will involve completion of the route, cause and analysis (RCA)

3 Initial history taking and safeguarding decision guide completion

3.1 Before considering the following questions please read Appendix 1 as this will give further guidance as to how to conduct the decision guide process.

3.2 The assessment must consider six key questions:

3.3 The six questions shown below together indicate a safeguarding decision guide score (Appendix 5). This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the potential of neglectful care/management resulting in the pressure ulceration. It is **not** a tool to risk assess for the development of pressure damage.

3.4 The threshold for referral is 15 or above. However this should not replace professional judgement**.**

1. Has the patient's skin deteriorated to either single category/grade 3 or category/grade 4 (to include unstageable/suspected deep tissue injury) or multiple category/grade 2 from healthy unbroken skin since the last opportunity to assess/visit
2. 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 http://www.epuap.org/wp-content/uploads/2012/07/SCALE-Final-Version-2009.pdf
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
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

5. Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk – Category 3 or category 4 pressure ulcer.

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

7. Was the patient compliant with the care plan having received information regarding the risks of non-compliance?
8. Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice?
9. NHS England (London Region) Principles of Best Practice in Safeguarding and Pressure Ulcer reporting-2014 (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?

3.5 Photographic evidence to support the report should be provided wherever possible. Consent for this should be sought as per local policy.

3.6 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 must both sign a body map (Appendix 3).

3.7 Documentation of the pressure ulcer must include site, size (centimetres) and category. You must record your assessment on the Safeguarding Pressure Ulcer decision guide, see Appendix 5.

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

3.9 Where the score is 15 or higher, or where professional judgement determines safeguarding concerns, a copy of the completed decision guide, along with a completed adult safeguarding concern proforma regarding pressure ulceration, should then be sent to the Adult Safeguarding team within the local authority. Copies of both should also be retained in the service users' electronic/paper notes.

3.10 When the protocol 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.

Acknowledgements/References

These guidelines have been developed with reference to:

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Lewisham Primary Care Trust, London Borough of Lewisham, University Hospital Lewisham. Joint Protocol for Determining Neglect in the Development of a Pressure Ulcer (30th November 2007)

Lambeth and Southwark Safeguarding Adults Partnership Boards: Safeguarding Adults and Skin Damage Protocol: Deciding whether to refer to the Safeguarding Adults Procedures Acute Trusts Subgroup (September 2009)

Mental Capacity Act 2005 Chapter 9 London: The Stationery Office

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http://www.epuap.org/gltreatment.html

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Skin Changes at Life's End: Final Consensus Statement
http://www.epuap.org/wp-content/uploads/2012/07/SCALE-Final-Version-2009.pdf

Tissue Viability Society, 2012, Achieving Consensus in Pressure Ulcer Reporting. Available online at:
http://tvs.org.uk/wp-content/uploads/2013/05/TVSConsensusPUReporting.pdf

GUIDANCE FOR USE WITH THE SAFEGUARDING Decision Guide (Appendix 1)

Structure for assessment

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 which may impact on skin integrity; such as Rheumatoid Arthritis, COPD, chronic oedema or steroid use.

- Is the person receiving palliative care/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.[10]

- 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 refuse/decline monitoring? If so, did the person have the mental capacity to refuse such monitoring?[11]
- Were any further measures taken to assist understanding e.g. patient 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 persons 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 District Nurse or Tissue Viability Specialist Nurse

[10] Family have no right to refuse monitoring

[11] The person's consent to monitoring should always be sought, but if the person lacks the metal capacity to make a decision as to whether monitoring should take place, then the decision as to whether and, if so, how monitoring should take place should be made in the person's best interests.

- Was advice provided? If so was it followed?

Care planning & implementation for management of skin integrity

- Was a pressure ulcer risk assessment carried out 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 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 provided in a timely manner/in line with local timescales?
- Was the specialist equipment used appropriately?
- Was the care plan revised within appropriate time scales?

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 patient 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

Single 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 local authority via local procedure, 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.

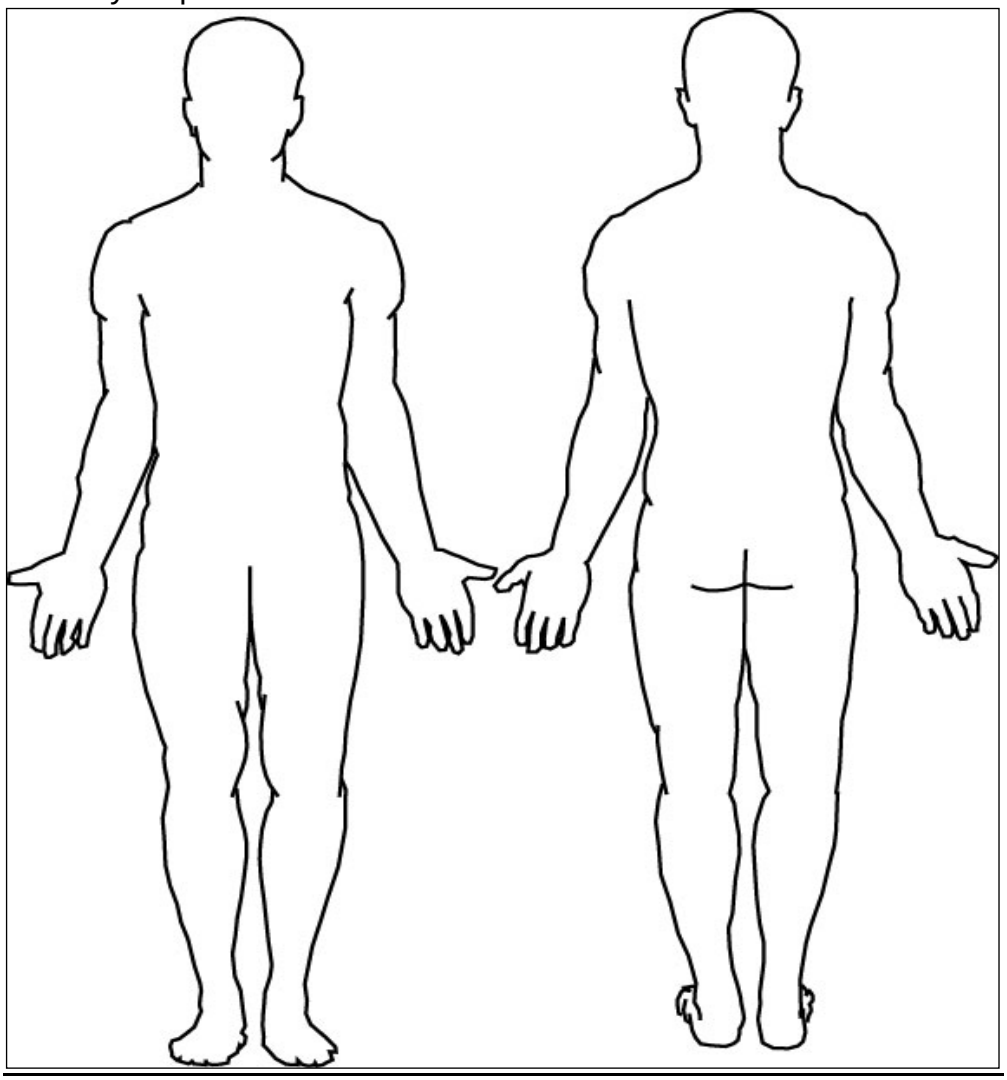
3. Record decision in person's records.

Complete Appendix 3, 4 & 5 and send <u>anonymised</u> copies to Haringey CCG c/o:
pressureulcerprotocol@nhs.net

Appendix 3

Body map

Body maps must 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 4

Adult Safeguarding referral regarding pressure ulceration

Details of individual with pressure ulcer(s)			
First name		Last name	
D.O.B		NHS Number	
Address		Borough of usual residence	

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/referral	

Synopsis of concern regarding pressure ulceration and safeguarding	
State site and Category of all pressure ulcer(s)	
Decision guide Score	
Summary/ rational for decision re safeguarding referral	

Safeguarding referral ☐

Not for safeguarding referral ☐

Reverse side of Appendix 4.

3.0 Initial history taking and safeguarding decision guide completion

3.3 The six questions shown below together indicate a safeguarding decision guide score (Appendix 5). This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the potential of neglectful care/management resulting in the pressure ulceration. It is **not** a tool to risk assess for the development of pressure damage.

3.4 The threshold for referral is 15 or above. However this should not replace professional judgement**.**

1. Has the patient's skin deteriorated to either single category/grade 3 or category/grade 4 (to include unstageable/suspected deep tissue Injury) or multiple category/grade 2 from healthy unbroken skin since the last opportunity to assess/visit?
2. 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 http://www.epuap.org/wp-content/uploads/2012/07/SCALE-Final-Version-2009.pdf
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
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?
5. Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk –Category 3 or category 4 pressure ulcer.
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?
b) Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice?

Appendix 5

Q	Risk Category	Level of Concern	Score	Evidence
1	Has there been an unexpected deterioration in the patient's skin integrity from the last opportunity to assess?	Progressive onset / deterioration of skin integrity	5	
		Sudden onset / deterioration of skin integrity	0	
2	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	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 3 or category 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 all of the care			
a	Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Patient not compliant with care plan	0	
		Patient compliant with some aspects of care plan but not all	3	
		Patient compliant with 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				

Patient Name:…… Patient No:……

Safeguarding Referral ☐ **Not for Safeguarding Referral** ☐

Appendix 5
Adult Safeguarding Decision Guide for patients with pressure ulcers

GUIDANCE FOR USE WITH THE SAFEGUARDING Decision Guide (Appendix 1)
Structure for assessment

Reverse side of Appendix 5
GUIDANCE FOR USE WITH THE SAFEGUARDING Decision Guide (As in Appendix 1)

Structure for assessment

History

- Include any factors associated with the person's behaviour that should be taken into consideration

Medical history

- Does the person have a long term condition which may impact on skin integrity; such as Rheumatoid Arthritis, COPD, chronic oedema or steroid use.
- Is the person receiving palliative care/ 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 [12]
- 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 refuse/decline monitoring? If so, did the person have the mental capacity to refuse such monitoring?[13]
- Were any further measures taken to assist understanding e.g. patient 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 persons 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 District Nurse 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 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 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 provided in a timely manner/in line with local timescales?
- Was the specialist equipment used appropriately?
- Was the care plan revised within appropriate time scales?

[12] Family have no right to refuse monitoring
[13] The person's consent to monitoring should always be sought, but if the person lacks the metal capacity to make a decision as to whether monitoring should take place, then the decision as to whether and, if so, how monitoring should take place should be made in the person's best interests.

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 patient 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?

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.

Acknowledgements

These guidelines have been developed with reference to the following:

- Barts Health NHS Trust. Hospital Pathway for Reporting and Investigating Pressure ulcers (including Safeguarding Adults processes).

- Bath and NE Somerset Local Safeguarding Adults Board. Protocol for Determining Neglect in the development of a Pressure Ulcer.

- Bradford Protocol for Determining Neglect in the Development of a Pressure Ulcer

- Chelsea and Westminster NHS and the Royal Borough of Kensington and Chelsea. Safeguarding Adults and Pressure Ulcer Protocol: Deciding whether to refer to the Safeguarding Adults Procedure.

- Dorset county Council. Section 4.2. Practice Guidance – Guidance on when Pressure Ulcers, Nutrition/Hydration and Falls Become a Safeguarding Issue.

- Greenwich Clinical Commissioning Group and Royal Greenwich Safeguarding Adults Board. Nursing Home Pressure Ulcer and Safeguarding Adult Protocol.

- Lambeth and Southwark Safeguarding Adults Partnership Boards Acute Trusts Subgroup Including King's College Hospital. Safeguarding Adults and Skin Damage Protocol: Deciding whether to refer to the Safeguarding Adults Procedures.

- Lancashire County Council, NHS and Lancashire Care Association In Partnership with the Safeguarding with Providers Group a sub group of Lancashire.

- Safeguarding Adults Board. Best Practice Guidance for Safeguarding Individuals with Pressure Ulceration.

- NENE Clinical Commissioning Group, Corby Clinical Commissioning Group, Northamptonshire County Council, Northamptonshire NHS Foundation Trust, Kettering General Hospital NHS Foundation Trust, Northampton General Hospital NHS Trust. Reporting Process for Patients with Pressure Ulceration – Version 3.0 May 2013.

- NHS Hertfordshire. Pressure Ulcers, Quality Assurance and Adult Safeguarding Guidance.

- NHS Wales. Pressure Ulcer Reporting and Investigation All Wales Guidance.

- Nottingham City Care. Pressure Ulcers -Safeguarding Triggers-Pathway 1.

- Southwark and Lambeth Safeguarding Adults Board. Safeguarding Adults and Pressure Ulcers: Decision Making Guidance.

- South Yorkshire and Bassetlaw NHS. Safeguarding Adults and Skin Damage Protocol: Deciding whether to refer to the Safeguarding Adults Procedures.

- University College Hospitals London NHS Foundations Trust. Safeguarding Adults.