Richmond Safeguarding Adults Board

Joint Safeguarding Adults Protocol

on how to undertake Safeguarding Adults Enquiries for different types of

Pressure Ulcers

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Hounslow and Richmond Community Healthcare NHS
NHS Trust

Kingston Hospital NHS
NHS Foundation Trust

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THE ROYAL BOROUGH OF KINGSTON UPON THAMES

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1. Introduction

1.1. Safeguarding is defined as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults.

1.2. Pressure ulcers develop when the skin integrity breaks down. This may be caused by poor practice, acts of omission or neglect but in some instances they are unavoidable.

1.3. This protocol will enable health and social care staff to identify if it is likely the pressure ulcer was caused as a result of neglect and whether an enquiry under the safeguarding procedures should take place. It will provide a focus on thresholds for referral through the safeguarding adult process. It is based on the multiagency integrated pressure ulcer pathway developed by NHS England In May 2014.

2. Purpose of the Protocol

2.1. This multi-agency protocol has been developed to assist in decision making as to whether to report a pressure ulcer as a safeguarding concern. It provides a 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.

2.2. It provides guidance for staff in all sectors who are concerned that a pressure ulcer may have arisen as a result of neglect/abuse or act of omission and therefore have to decide whether to make a referral to social services. A flow diagram outlining the key elements of the protocol can be found in Appendix 1.

2.3. Each organisation is responsible for ensuring that the protocol is used appropriately and monitor and review its use. This would include reviewing decisions to raise or not raise concerns within internal governance processes.

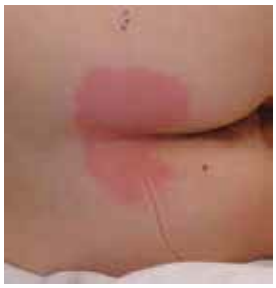
3. Pressure ulcers and safeguarding

3.1. 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.

3.2. 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.

3.3. There are **Six** recognised stages of pressure ulcers in the Wound Classification system drawn up by the European Pressure Ulcer Advisory Panel (EPUAP 2014). See below

INTERNATIONAL NPUAP/EPUAP PRESSURE ULCER CLASSIFICATION SYSTEM (2014)

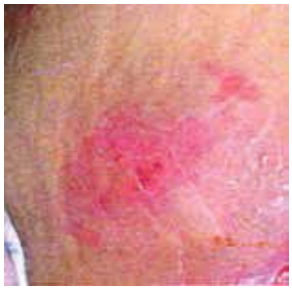


Category/Stage I: Nonblanchable Erythema

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones.

May indicate “at risk” individuals (a heralding sign of risk).

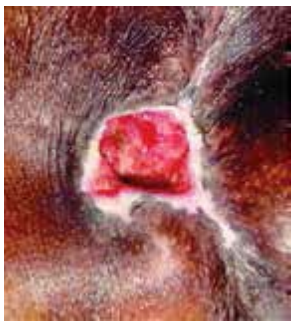


Category/Stage II: Partial Thickness Skin Loss

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 serumfilled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

**Bruising indicates suspected deep tissue injury.*



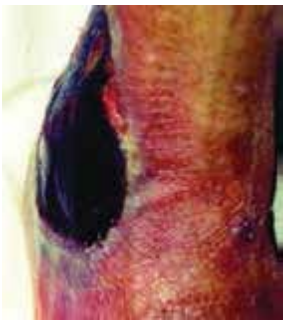
Category/Stage III: Full Thickness Skin Loss

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed.

Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Category/Stage IV: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.



Unstageable: Depth Unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined.

Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected Deep Tissue Injury: Depth Unknown

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar.

Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

4. Managing Pressure Ulcers in context of Adult Safeguarding

4.1. As outlined in the NHS England 2014 Guidance, all cases of single Stage 2 pressure ulcers require early intervention to prevent further damage. If there are concerns regarding poor practice, a clinical incident must be raised and investigated through the NHS provider organisations own procedures.

4.2. Any unstageable, or stage 2 and above pressure ulcers MUST be reviewed under the pressure ulcer criteria and a serious incident (SI) reported according to local clinical governance procedures.

4.3. A safeguarding referral should be made if there is:

- Significant skin damage (i.e. Stage 3 or 4,unstageable ulceration or multiple stage 2s) and
  - o There are reasonable grounds to suspect that it was avoidable or
  - o Inadequate measures taken to prevent development of pressure ulcer (including informal carers preventing access to care or services), or
  - o Inadequate evidence to demonstrate the above

4.4. In deciding about the need for a safeguarding referral, a history of the problem should first be obtained, contact former care providers for information if the person's care has recently been transferred, and seek clarification about the cause of the damage.

4.5. Safeguarding concerns should be raised when pressure ulcers are reported by anyone including carers, relatives and patients, as any tissue damage no matter who reports it should be investigated.

5. Procedure to determine if a pressure ulcer is due to neglect of an adult at risk

5.1. As soon as a pressure ulcer stage 3 or 4 is identified there should be an assessment of the wound by the team responsible for that individual's treatment. Completion of the pressure ulcer decision guide (see Appendix 2) must be completed by a qualified member of staff who is a practicing registered nurse, with experience in wound management. This does not have to be a Tissue Viability Nurse.

5.2. The safeguarding decision guide involves 6 key questions which together indicate a safeguarding decision guide score (See Appendix 2). 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. The threshold for referral is 15 or above. However this should not replace professional judgement.

5.3. Photographic evidence should be used to support the report wherever possible, provided that the service user consents. Body maps should 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. Documentation of the pressure ulcer must include site, size (centimetres) and category/stage.

5.4. The Safeguarding Decision Guide should be completed immediately or within 3 working days of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension must be documented.

5.5. Where the patient 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 a safeguarding concern has been raised or the decision guide has been completed; if neither then a safeguarding concern should be raised with the local authority.

6. Delegated enquires

6.1. The Care Act 2014, provides local authorities with the opportunity to "cause others to undertake enquiries", which is referred to as "delegating responsibility" for leading safeguarding enquiries. In the case of pressure ulcers, in many instances health care professionals within the organisation responsible for that individual's treatment will be best placed to lead these enquiries and so delegation should always be considered in the management of pressure ulcers. The process for determining whether or not undertaking an enquiry into a pressure ulcer should be delegated to the provider organisation is summarised in Appendix 1.

6.2. When the pressure ulcer protocol has been completed and there is no indication of neglect, the completed screening tool should be stored in the patient's notes and a record kept of the screening outcome.

6.3. Where there is a cause for concern, a safeguarding referral must be made to the local authority. The professional making the referral should have a discussion with the designated local authority decision maker as to whether there should be a multi-agency safeguarding enquiry or if the enquiry should be delegated to the provider organisation. A summary of the discussion will be recorded by the local authority and shared with the agencies involved in the discussion.

6.4. If the enquiry is delegated to the reporting health partner, the work of the enquiry will involve either a concise or a comprehensive Root Cause Analysis. This should be completed by an appropriately skilled and trained person such as District nurse team lead, ward manager or nursing home manager in line with the providers pressure ulcer or risk management policies.

6.5. The principles of Making Safeguarding Personal should be adhered to and therefore there should be a discussion with the patient (and/or their representative or advocate) in terms of what they want to happen in terms of undertaking an enquiry. It should be clearly agreed who will have this discussion. In determining who it is most appropriate to hold the discussion with the principles of the Mental Capacity Act should be considered.

6.6. The outcome of the Root cause Analysis findings should be sent to the local authority. This will include information on:

6.7. Whether the concerns were substantiated, not substantiated or inconclusive

6.8. Whether the person's outcomes were met

6.9. The impact of the enquiry on the person's sense of safety and well being

6.10. The actions to be undertaken to embed learning

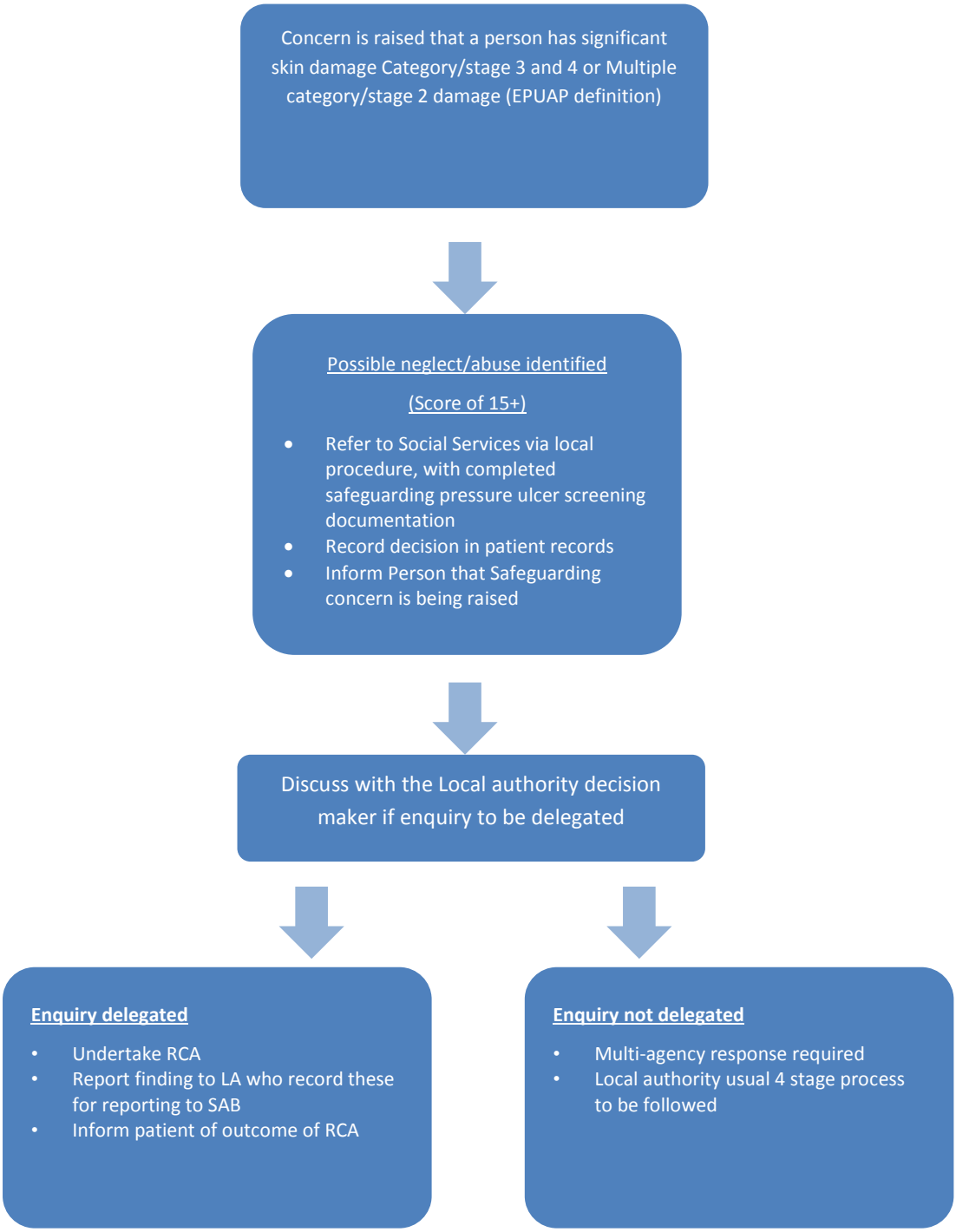
6.11. The local authority officer will record the information from the delegated enquiry for reporting to the Safeguarding Adults Partnership board.

6.12. If a full enquiry is to be undertaken the local authority will lead on the enquiry following local procedures.

7. Review

7.1. This protocol will be reviewed annually in July 2017.

Appendix 1: Pressure Ulcer Delegation of enquiry process chart



Appendix 2: Pressure Ulcer decision Guide

Firstly consider has the patient's skin deteriorated to either stage 3/4/unstageable or multiple sites of stage 2 ulceration from healthy unbroken skin?				
Q	**Risk Category**	**Level of Concern**	**Score**	**Evidence**
1	Has there been a recent change, days or hours, 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	
2	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? Is the care plan in line with each organisation's 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 not carried out	15	What elements would have been expected to be in place but were not
3	Is there a concern that the Pressure Ulcer developed as a result of the informal carer ignoring or preventing access to care or services?	No / Not applicable	0	
		Yes	15	
4	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk but with a Category/stage 3 or 4 pressure ulcer or multiple stage 2.	Skin damage is less than or equal to what would be expected given the patient's risk assessment	0	
		Skin damage more severe and disproportionate to risk assessment.	10	
5	**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 plan**			
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	5	
		Patient not given sufficient information or supported to understand the risks 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 refer as a safeguarding concern. Send this form as your safeguarding referral.

When the protocol has been completed, even when there is no indication that a safeguarding concern needs to be raised the tool should be stored in the patient's notes