Safeguarding Adult Guidance:

Pressure Ulcers and the interface with Safeguarding within Kirklees

Version 1 April 2022

1.0 Introduction

This document reflects the six principles of safeguarding adults as identified within the Care Act 2014. It provides guidance for all staff in all organisations/services that may see a pressure ulcer where there are concerns that the ulcer may have occurred due to inadequate practice, neglect or abuse, or an act of omission.

A pressure ulcer should be defined as localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical device or other devices) resulting from sustained pressure (including pressure associated with shearing):

- Shearing is the separation of skin from underlying tissue for example when a person is partially sitting up where the person's skin may stick to the sheet, causing the underlying tissue to move downward from the body.

Pressure ulcers are key indicators of quality and experience of care. Those at risk of pressure ulcers are cared for in many different settings across Health and Social Care including their own home. Priority is the prevention of pressure ulcers and requires a proactive approach to reduce harm to individuals. However, it is recognised not all pressure ulcers can be prevented though risk factors must be assessed on an individual basis.

When they do occur pressure ulcers can have a profound impact on quality of life for individuals and represents a challenge psychologically and physically for that person, their family, and carers. They create extra financial burden on the health service and whilst the response and treatment are usually a clinical one the prevention of harm is a shared responsibility for all services.

2.0 Purpose

The purpose of this document is to provide a locally agreed response and consistent standard approach for all about how and when the development of a pressure ulcer might be considered as a safeguarding concern and when a safeguarding response under section 42 of the Care Act may be required. Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry 2018

Organisations/services are expected to have procedures to record and monitor incidents related to pressure ulcers and decisions made related to those incidents. If they believe a person has experienced or is at risk of experiencing abuse or neglect, then raising a safeguarding concern related to the pressure should be considered.

Below are links to guides to help decide when a pressure ulcer/s may be needed to be raised as a safeguarding concern and whether further enquiries are required.

Appendix 1: Pressure Ulcers: When to raise an Adults Safeguarding Concern

Appendix 2 Adult Safeguarding Decision Guide Assessment for Individuals with Pressure Ulcers:

3.0 Guidance

Definitions:

There are six categories of pressure ulcers defined by the National Pressure Injury Advisory Panel

- Category I: non-blanchable
- Category II: partial thickness skin loss
- Category III: full thickness skin loss
- Category IV: full thickness tissue loss with exposed muscle or bone
  Deep tissue Injury - usually an unbroken area - depth unknown
- Unstageable: Obscured full-thickness skin and tissue loss, extent of skin damage cannot be confirmed.

Additional definitions:

- Medical Device Related Pressure: results from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure generally conforms to the pattern or shape of the device. The damage should be categorised using the above system.

Organisations/ Services reporting processes:

- Early prevention and intervention are key to prevent damage and/or further damage.
- Severe damage can be classed as multiple category 2's, single category 3 or 4 (including unstageable or deep tissue injury).
- Pressure ulcers from medical devices must be recorded from where they have been developed for example: urinary catheters, oxygen masks, orthotic shoes.
- Moisture associated skin damage is not a pressure ulcer, though moisture can be present at the same time as pressure. If both are present the moisture associated skin damage should be reported in addition to the pressure ulcer/s. The category of pressure must be recorded separately.
- Organisations/services must have agreed internal reporting procedures in place for pressure ulcer reporting - NHS Improvement Pressure Ulcer Guidance 2018
- If an internal investigation is required, this should be completed by the organisation/service that was responsible for that individual's care at the time of pressure ulcer development. The investigation must be line with the organisations local policies and procedures.
- Ensure open and transparency with the individual, family and/or advocate and follow the Duty of Candour principles
- If a professional has safeguarding concerns, escalation might be via the organisations/services own local reporting procedures in the first instance.
- Remember when a pressure ulcer is identified it must be assessed, documented and appropriate preventative measures/actions put in place. Any immediate learning should be identified, addressed, and shared.

Interface with Safeguarding:

- **Individual develops pressure ulcer/s in organisation/service care** - When a pressure ulcer has been identified and reported there may be a need to consider whether there are any safeguarding concerns as to why the pressure ulcer developed?
- Appendix 2 Adult Safeguarding Decision Guide Assessment for Individuals with Pressure Ulcers is a supportive tool to aid decision making and can be used to assist staff with whether a pressure ulcer might meet the threshold of a safeguarding concern. This should ideally be completed by the most appropriate trained member of staff to aid with that decision making.

- **Individual transferred into another organisation/service care with a pressure ulcer/s** - When an individual has been transferred into another organisation's care and a pressure ulcer has been identified and reported there may be a need to consider whether there are any safeguarding concerns as to why the pressure ulcer developed? It would be good practice to complete the assessment (Appendix 2 Adult Safeguarding Decision Guide Assessment for Individuals with Pressure Ulcers), however it is noted that on some occasions that this may not be feasible. It is important that any information should be gathered from the transferring organisation and a decision made locally whether the category of pressure ulcer/s, and any other concerns about the individual's presentation and their care constitutes a safeguarding concern. The reasons why should be discussed with the transferring service.

- On the assessment the threshold for raising a Safeguarding Concern is 15 or above. Appendix 2 Adult Safeguarding Decision Guide Assessment for Individuals with Pressure Ulcers However this is still a guide and a supportive tool to aid decision making. Professional judgement can be used when deciding whether to raise a safeguarding concern. There must be a clear, concise rational decision-making process which must be fully documented.

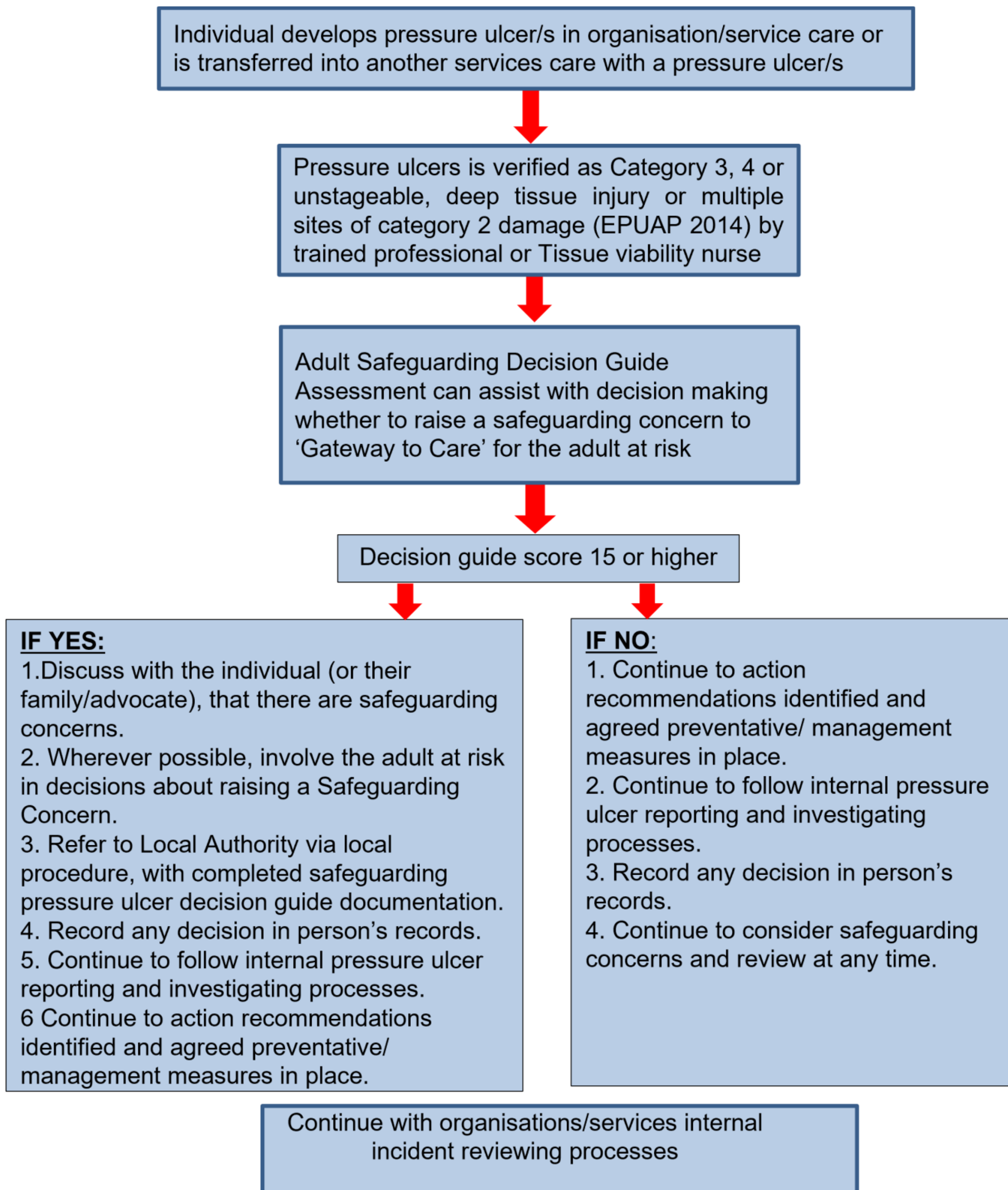
- There can be a variety of reasons why individuals might have pressure ulcers, and these do not always meet the threshold of a safeguarding concern. Appendix 1: Pressure Ulcers: When to raise an Adults Safeguarding Concern, Appendix 2 Adult Safeguarding Decision Guide Assessment for Individuals with Pressure Ulcers are there to assist you in this decision making on whether the pressure ulcer might meet concerns around safeguarding.

- Making Safeguarding Personal – the individual (or their family/advocate) must be involved in the decision to raise a Safeguarding concern and their consent sought to be involved in further enquiries. Desired outcomes of the individuals must be sought and acted upon.

- A decision whether a Section 42 enquiry is required will be undertaken by Local Authority informed by Health in relation to the development of the pressure ulcer. A summary of the decision must be recorded and shared with all agencies involved.

Appendix 1: Pressure Ulcers: When to raise an Adults Safeguarding Concern

This guidance based on Pressure **Ulcers and the interface with a Safeguarding Enquiry: When to raise an Adults Safeguarding Concern (DH 2018),** provides a framework to identify if an individual who has developed a pressure ulcer is:
1) primarily an issue for an internal investigation/review or
2) requires a safeguarding concern to be raised so that a safeguarding response under section 42 of the Care Act can be considered.



Appendix 2 Adult Safeguarding Decision Guide Assessment for Individuals with Pressure Ulcers:

	Risk Category	Level of Concern		Evidence	
1	Risk Category Has the patient's skin deteriorated to either category 3/4/ unstageable or multiple category 2 from healthy unbroken skin since the last opportunity to assess/ visit	Yes, for example record of blanching / non-blanching erythema	Score 5	Evidence for example, evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided	
1 continued	Risk Category Has the patient's skin deteriorated to either category 3/4/ unstageable or multiple category 2 from healthy unbroken skin since the last opportunity to assess/ visit	Level of Concern No for example no previous skin integrity issues or no previous contact health or social care services	Score 0		
2	Risk Category Has there been a recent change, for example within days or hours, in their / clinical condition that could have contributed to skin damage? For example, infection, pyrexia, anaemia, end of life care, critical illness	Level of concern Change in condition contributing to skin damage	Score 0		
2 continued	Risk Category Has there been a recent change, for example within days or hours, in their / clinical condition that could have contributed to skin damage? For example, infection, pyrexia, anaemia, end of life care, critical illness	Level of concern No change in condition that could contribute to skin damage	Score 5		
3	Risk Category 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	Level of concern Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	Score 0	Evidence State date of assessment Risk tool used Score / Risk level	
3 continued	Risk Category 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	Level of concern Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	Score 5	Evidence What elements of care plan are in place?	
3 Continued	Risk Category 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	Level of concern No or incomplete risk assessment and/or care plan carried out	Score 15	Evidence What elements would have been expected to be in place but were not	

4	Risk category 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	Level of concern No/Not Applicable	0		
4 continued	Risk category 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	Level of concern Yes	Score 15		
5	Risk category Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? For example low risk–Category 3 or 4 pressure ulcer	Level of concern Skin damage less severe than patient's risk assessment suggests is proportional	Score 0		
5 continued	Risk category Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? For example, low risk–Category 3 or 4 pressure ulcer	Level of concern Skin damage more severe than patient's risk assessment suggests is proportional	Score 10		
6	Risk Level 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.				
6a.	Risk level – Patient has capacity Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Level of concern Patient has not followed care plan and local non-Concordance policies have been followed.	Score 0		
6a continued	Risk level – patient has capacity Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Level of concern Patient followed some aspects of care plan but not all	Score 3		
6a continued	Risk level – patient has capacity. Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Level of concern Patient followed care plan or not given information to enable them to make an informed choice.	Score 5		

6b	Risk level – patient lacks capacity 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, for example capacity and best interest statements and record of care delivered)	Level of concern Documentation of care being undertaken in patient's best interests	Score 0		
6b continued	Risk level – patient lacks capacity 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, for example capacity and best interest statements and record of care delivered)	Level of concern No documentation of care being undertaken in patient's best interests	Score 10		
Total	Add up the scores				

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 with the patient's local incident reporting form