Pressure ulcers and safeguarding adults

Kirklees Safeguarding Adults Board guidance and procedure on when pressure ulcers should be reported as an Adult’s Safeguarding Alert.
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**Introduction**

This guidance is for all staff in all sectors within the Kirklees area whether hospital, care home or community setting, who are working with people who develop pressure ulcers that may have been caused by neglect or poor practice. All cases of alleged neglect need to be reported as an adults safeguarding alert.

There is a link that can exist between the development of significant pressure ulcers and the possible poor practice or neglect in the person’s care which needs to be considered under safeguarding adults.

This guidance has been developed in conjunction with safeguarding leads from Health Trusts, Locala, Clinical Commissioning Groups (CCGs) and Tissue Viability Nurses (TVN).

**Staff should also refer to:**
- [West Yorkshire Safeguarding Adults Policy and Procedures](#)
- their own organisation’s policies and procedures on pressure ulcers
- other relevant local and national guidelines, protocols and policies e.g. NICE guidance and incident reporting policies
What is a pressure ulcer?

A pressure ulcer is a localised injury to the skin and/or underlying tissue, usually over a bony prominence as a result of pressure or pressure in combination with shear. A number of contributing or compounding factors are also associated with pressure ulcers; the significance of these factors is yet to be made clear (International NPUAP-EPUAP pressure ulcer definition 2009).

The Department of Health/National Patient Safety Agency define a pressure ulcer as either avoidable or unavoidable:

### Avoidable pressure ulcer

“Avoidable” means that the person receiving care developed a pressure ulcer and the provider of care did not do one or more of the following:

<table>
<thead>
<tr>
<th>Avoidable pressure ulcer</th>
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<tbody>
<tr>
<td>“Avoidable” means that the person receiving care developed a pressure ulcer and the provider of care did not do one or more of the following:</td>
</tr>
<tr>
<td>• Evaluate the person’s clinical condition and pressure ulcer risk factors; (e.g. no evidence of risk assessments, Waterlow and Malnutrition Universal Screening Tool [MUST])</td>
</tr>
<tr>
<td>• Plan and implement interventions that are consistent with the person’s needs and goals (e.g. no evidence of repositioning, turn charts, patient leaflet IMPACT, equipment, mattress and seating)</td>
</tr>
<tr>
<td>• Recognise standards of practice (e.g. no referral to Tissue Viability Nurse [TVN], carry out risk assessments)</td>
</tr>
<tr>
<td>• Monitor and evaluate the impact of the interventions (e.g. no monitoring or evaluation of the equipment, repositioning)</td>
</tr>
<tr>
<td>• Revise the interventions as appropriate</td>
</tr>
</tbody>
</table>

### Unavoidable pressure ulcers

“Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider:

<table>
<thead>
<tr>
<th>Unavoidable pressure ulcers</th>
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<tbody>
<tr>
<td>“Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider:</td>
</tr>
<tr>
<td>• Evaluated the person’s clinical condition and pressure ulcer risk factors (e.g. evidence of risk assessments, Waterlow and MUST)</td>
</tr>
<tr>
<td>• Planned and implemented interventions consistent with the person’s needs and goals (e.g. evidence of repositioning, turn charts, patient leaflet IMPACT, equipment, mattress and seating)</td>
</tr>
<tr>
<td>• Recognised standards of practice (e.g. referral to TVN was made)</td>
</tr>
<tr>
<td>• Monitored and evaluated the impact of the interventions</td>
</tr>
<tr>
<td>• Revised the approaches as appropriate</td>
</tr>
<tr>
<td>• Or (Concordance or compliance issues) the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence” (documented evidence of verbal instructions and that TVN has been informed)</td>
</tr>
</tbody>
</table>
Pressure ulcer prevention and management

It is widely accepted that pressure ulcers are, for the most part, preventable if:

- the circumstances which are likely to result in pressure ulcers are recognised
- those at risk are identified early
- appropriate prevention measures are implemented without delay

Organisations should follow their local and national guidance on prevention and management of pressure ulcers.

On admission at the first episode of care a risk assessment using an appropriate tool e.g. Waterlow assessment tool should be performed and results documented in the person care records. Any identified care need should be met and clearly documented. Risk assessment should be ongoing and is the responsibility of the registered health care professionals working with that person (for further guidance see Appendix 1).

N.B. Registered healthcare professionals may not always be involved with patients at pressure ulcer risk e.g. where there has been a direct referral to a home care provider.

Pressure ulcers and neglect

Pressure ulcers can occur due to neglect whether this is deliberate or by omission of care.

Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support AND this has resulted in, or is highly likely to result in, a preventable pressure ulcer.

Not all pressure ulcers in an adult at risk are the result of neglect. Pressure ulcers could also be acquired by people in their own home, possibly due to self neglect or the individual themselves refusing help and advice. However consideration must be given as to whether neglect has occurred.

Pressure ulcers can occur in any environment and are generally avoidable. They cause pain and discomfort. When present pressure ulcers require monitoring and appropriate treatment in order to prevent unnecessary pain and suffering for the person concerned.

Omission of care or poor practice that has resulted in a person developing a pressure ulcer and therefore suffering harm must be reported using the Safeguarding Adults Procedures.
The following are likely indicators of poor practice:

- no assessment or reassessment of risk
- failure to act upon findings of risk assessment
- lack of appropriate equipment
- poorly maintained equipment
- staff not trained in using equipment
- staff not trained in manual handling
- staff not having an awareness of pressure ulcer prevention and management
- nutritional assessments not completed
- repositioning charts not used or not clearly completed
- specialist advice has not been sought
- care plans and records are not clear and concise and up to date

The person’s mental capacity to agree to their care must also be assessed. Records should be kept of the person’s compliance with their care plan as well as any best interest decision where the person lacks capacity.

**Standards of practice when someone develops a category 3 or 4 pressure ulcer:**

1. In the Kirklees area Tissue Viability Services have been commissioned to provide advice and support to residents, carers and health care professionals. Referrals should be made to the Tissue Viability Service for:

- all people who have a category 3 or 4 pressure ulcer
- people with a deteriorating pressure ulcer
- people with a difficult to manage wound/pressure ulcer
- people with whom you have difficulty involving and/or compliance with medical advice

Referrals to the TVN service can be made by doctors, nurses, colleagues, patients, carers, care homes, GP practices.

There are two Tissue Viability teams in Kirklees:

North:  01924 512157
South:  01484 355396

The Care Quality Commission should be notified of any category 3 and 4 pressure ulcer along with the completion of your organisation’s incident reporting system.
2. Where a category 3 or 4 pressure ulcer has developed, consideration should be given to the possible cause being neglect. Where this is the case it requires reporting as an adults safeguarding alert. This includes whether or not the person acquired the pressure ulcer in the hospital, care setting or their own home.

Organisations, including residential homes with nursing, must make a decision as to whether an adults safeguarding alert needs to be made. If neglect is suspected an adults safeguarding alert should be made.

**The pressure ulcer decision support tool Appendix 2 should be completed.**

If you are aware an adults safeguarding alert has already been made prior to admission, unless the pressure ulcer has deteriorated further whilst in your care, there may not be a need to raise an adults safeguarding alert. You can contact the Safeguarding Adults team for further advice and guidance on 01924 482112.

3. An investigation using root cause analysis (RCA) should be carried out as per local policy and recorded on appropriate documentation. Support or guidance from the TVN for all category 3 and 4 pressure ulcers, irrespective of whether an adults safeguarding alert is made or not. Responsibility for conducting a RCA would normally lie with the organisation responsible for the person’s care in the setting where the pressure damage developed.

Where an adults safeguarding alert has been made and a decision is reached to investigate, the RCA will form part of the investigation.

4. Treatment, evaluation, prevention and management of the pressure ulcer should be ongoing.
When to raise an Adults Safeguarding Alert

The flowchart below gives a referral pathway for pressure ulcers:

An individual develops pressure ulcers

- Catagory 1 or category 2 EPUAP pressure ulcers
- Have reasonable steps been made to prevent/manage pressure ulceration
  - Yes: Seek advice where required from the Tissue Viability Service if there are management concerns or District nurse for community or residential homes
  - No: Seek advice from the Tissue Viability/ District Nurse to address quality issues with training and management advice. Consideration may be given to a safeguarding referral.

- Category 3 or catagory 4 EPUAP pressure ulcers
- Have reasonable steps been made to prevent/manage pressure ulceration. Use pressure ulcer screening tool
  - Yes: Refer to the Tissue Viability Service Also for community and nursing homes Intermediate care and/or District Nurse for management.
  - No: Multi Agency Safeguarding Alert to be made. Refer to the Tissue Viability Service and for community and nursing homes refer Intermediate Care/ District Nursing for management.
What happens after an Adults Safeguarding Alert is made:

Once an adults safeguarding alert is made to Kirklees Council the West Yorkshire Safeguarding Adults Policy and Procedures are followed to decide an outcome, assess risk and plan intervention. The guidance below is in addition to what is in the policy and procedures.

Alerts and decision making:

1. Adult Safeguarding Operational Team (ASOT) to contact the alerter and relevant nurse within the organisation (where applicable) from where the pressure ulcer adults safeguarding alert is reported to gather further information. This includes information and copy of the pressure ulcer screening.

2. Contact made with the alerter and any other relevant people e.g. safeguarding leads within the health organisation.

3. Seek the view of the adult at risk, family, advocate etc.

4. Contact TVN to discuss their view, involvement and awareness of the pressure ulcer:
   
   North: 01924 512157
   South: 01484 355396

5. Decision made to proceed to strategy: If the initial assessment reveals potential neglect:

Strategy meeting/discussion:

1. Meeting or discussion takes place involving relevant people involved with the adult at risk and TVN or other appropriate clinical professional who can provide information about the pressure care.

2. Views of the adult at risk sought (where possible).

3. Action taken to prevent further harm/development of protection plan discussed.

4. Decision made to either proceed to investigation or close only in cases where the initial assessment indicates no neglect (the RCA would still need to be carried out by the relevant professionals) or in cases where the RCA has already been carried out and shows that no neglect took place.
5. If investigation needs to take place:

Discussion and decision will be made led by the Safeguarding Coordinator on what the investigative tasks are and who will be responsible for carrying out the activities.

For all pressure ulcer related safeguarding investigations there should be a report produced by a TVN or professional with clinical expertise on determining if the pressure ulcer was avoidable or unavoidable. The report is based on the findings from the RCA. It would also be discussed who would be carrying out the RCA. This report could be produced by the TVN or other clinical professional and could sometimes be done by the organisation in which the pressure ulcer developed or who were delivering care, however there should be some involvement from the TVN in the report.

Investigation:

Investigation takes place as decided in the strategy meeting/discussion.

Case conference:

1. Feedback from professionals involved including the TVN or clinical professional.

   If people are unable to attend, ensure that a report is sent to the Safeguarding Coordinator prior to the case conference.

2. Determine if the pressure ulcer was avoidable or unavoidable.

3. Determine if neglect took place.

4. Agree actions.

5. Protection plan.

6. Arrange review of protection plan and review of actions where required.

7. Action on learning to be passed back to relevant agencies for action.

Exceptions:

There may be occasions where the initial assessment determines no neglect may have taken place, however, when a RCA is carried out if it reveals that the pressure ulcer(s) were avoidable and alleged neglect took place; on these occasions an adults safeguarding alert will need to be made and investigated appropriately.
Appendix 1  - NICE pathways 2012

**Person at risk of or with a pressure ulcer**
Perform initial risk assessment (Waterlow) in first episode of care. Initial and ongoing ulcer assessment is the responsibility of a registered healthcare professional.

**Assessing risk**
Risk factors include:
Pressure, shearing, level of mobility including walking, ability to reposition (for example in bed or a chair) or transfer, (for example from bed to chair) sensory impairment, continence, level of consciousness, acute, chronic and terminal illness, co morbidity, pain, posture, cognition, psychological status including ability to self-care, previous pressure damage, extremes of age, nutrition and dehydration moisture to the skin, social factors.
*Document the assessment of risk, noting all relevant factors.*
*Reassess on an ongoing basis and in particular if the person’s circumstances change.*

**Skin assessment**
Assess skin regularly:
Frequency should be based on vulnerability and condition of person being assessed. Inspect all vulnerable areas.
Encourage people (or their carers) to inspect the skin (using a mirror if necessary).

**Preventing pressure ulcers**
Provide appropriate preventative equipment without delay including mattress and cushion, document repositioning regime and use of repositioning chart if appropriate in care setting. Perform MUST assessment. Complete care plan. Limit the time an individual spends seated in a chair.

**Person with pressure ulcer**
Provide appropriate redistributing mattress and cushion, document repositioning regime and use of repositioning chart if appropriate in care setting. Perform nutritional assessment. Complete Care Plan.

**Reassess risk**
Reassess at least monthly, in particular if the person’s circumstances change.

**Assessing pressure ulcer**
Assess: cause, location, dimensions, including the longest length as an estimate of surface area, and depth (measured using a sterile probe), category, exudates (amount and type), local signs of infection, pain, including cause, level, location and management interventions, wound appearance, surrounding skin, undermining/tracking, sinus or fistula, odour.
Ensure initial and ongoing pressure ulcer assessment. Reassess frequently (at least weekly).

**Recording the pressure ulcer assessment**
Document depth and estimated surface area. Document category using EPUAP. Support document with photography and/or tracings (calibrated with a ruler). Pressure ulcers should not be reverse graded. A category 4 pressure ulcer does not become a category 3 as it heals. As the ulcer heals it should be described as a healing category 4 pressure ulcer. All pressure ulcers category 2 and above should be documented as a local clinical incident.

**Treatment and management**
A registered health professional should choose the dressing based on the wound care formulary.
# Appendix 2 - Pressure ulcer screening tool

Report to be completed when determining if development of a pressure ulcer (category 3 or 4) should lead to an adult’s safeguarding alert being made to Kirklees Council through West Yorkshire Safeguarding Adults Policy and Procedures

This form should be completed by a registered nurse in line with your organisational policy.

Please store a copy of the form on the patient service user records.

The content of this report is confidential. It should be shared with Kirklees Council if a safeguarding adult’s alert is made, in the best interests of the adult at risk.

<table>
<thead>
<tr>
<th>Name of patient/adult at risk:</th>
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<tbody>
<tr>
<td>Normal address of patient/service user:</td>
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<tr>
<td>DOB:</td>
</tr>
<tr>
<td>Hospital Number/NHS Number:</td>
</tr>
<tr>
<td>Place of current care:</td>
</tr>
<tr>
<td>Previous place of care (if appropriate):</td>
</tr>
<tr>
<td>GP or Consultant:</td>
</tr>
<tr>
<td>Documentation available at time of reporting (please list):</td>
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</tbody>
</table>

1. Where is the location of the pressure ulcer(s)?
   What category is the pressure ulcer (EUPAP 2009)?
2. Has there been a recent change in medical condition e.g. infection, pyrexia, anaemia, end of life care, chronic disease, sensory/neurological deficit, that could have contributed to skin damage?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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Give details:

3. Please indicate what Risk Assessment was used and the outcome (including risk assessment score/status and clinical judgement).

Does the score/risk status reflect the patient’s condition? When was the latest score calculated?

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4. Have the following steps been taken to prevent skin damage?

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<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
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<tbody>
<tr>
<td>Was a risk assessment tool completed prior to ulceration?</td>
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<tr>
<td>Was skin inspected with documentation prior to ulceration?</td>
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<tr>
<td>Was appropriate equipment installed in an adequate time frame?</td>
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<tr>
<td>Was a repositioning regime implemented and evidenced?</td>
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<tr>
<td>Was written literature given to the patient on pressure ulcer prevention?</td>
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<tr>
<td>Are there any identifiable barriers to preventing a pressure ulcer?</td>
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<tr>
<td>Is the patient in an appropriate care setting that meets their needs?</td>
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Comments:

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</table>
5. In your clinical opinion do you think that the development of the pressure ulceration was avoidable or unavoidable

<table>
<thead>
<tr>
<th>Avoidable</th>
<th>Unavoidable</th>
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Please give a rationale for your answer:

6a) If pressure ulceration was avoidable make Alert into safeguarding giving details of:

- Date adult’s safeguarding alert completed
- Current risk assessment and appropriate pathways
- Steps taken to manage the pressure ulcer(s)

6b) If pressure ulceration was unavoidable give rationale/recommendations for not referring into safeguarding:

- Current risk assessment and appropriate pathways
- Recommendations for practice/completion of RCA
- Referrals to Clinical Governance

Details member of staff completing this assessment:

<table>
<thead>
<tr>
<th>Name:</th>
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<tbody>
<tr>
<td>Title:</td>
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<tr>
<td>Place of work:</td>
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<tr>
<td>Qualifications:</td>
<td></td>
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<tr>
<td>Signed:</td>
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<tr>
<td>Date:</td>
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When completing the screening tool consider the evidence against the following criteria:

**Patient history**
- whether rapid onset and deterioration to a severe ulcer
- patient compliance with care plan/behaviour
- whether extensive damage in a low risk patient

**Co-morbidity**
- medical history
- chronic disease
- palliative care
- mental health issues

**Care regime**
- poor quality care: standard of assessment and use of relevant policy and procedures to support care and appropriate documentation with a plan of care
- whether appropriate equipment has been provided
- evidence implementation of plan of care
- continence management: hygiene
- deterioration of appearance
- general indicators of care – e.g. clean nails, oral care
- inappropriate prevention and treatment regimes
- recurrent pressure ulcers
- evidence of risk management

**Hydration and nutrition**
- evidence of intake monitoring
- fluid balance
- regular weighing (regular monitoring of weight)

**Under/over use of medication**
- note appropriate use of sedation if patient is immobile for extended periods
- is pain assessed and managed

**Contributory circumstances of pressure ulcers**
- detailed history of patient journey - e.g. environmental changes - change[s] in care setting[s]
- history of falls
- previous history of pressure ulcers
- carer involvement
- health and social care involvement
## Relevant contacts

<table>
<thead>
<tr>
<th>Unit</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Safeguarding Operational Team</td>
<td>01924 482112</td>
</tr>
<tr>
<td>Calderdale and Huddersfield Trust NHS Foundation Trust Safeguarding Team</td>
<td>01422 224570</td>
</tr>
<tr>
<td>Gateway to Care</td>
<td>01484 414933</td>
</tr>
<tr>
<td>Locala Safeguarding Team</td>
<td>07908 846011 or 07903 752465</td>
</tr>
<tr>
<td>Mid Yorkshire NHS Trust Safeguarding Team</td>
<td>01924 543689</td>
</tr>
</tbody>
</table>
| Tissue Viability Teams                                               | North: 01924 512157  
                          | South: 01484 355396                      |

This document will be reviewed in July 2014.
Information in other formats

Kirklees Council are committed to ensuring that our communication is clear, plain and available for everyone. This information can be made available in languages other than English. It can also be made available in large print, audio CD and Braille. Full details are available by telephoning 01484 414933.