

Central London Community Healthcare NHS Trust
Chelsea and Westminster Hospital NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
Royal Brompton and Harefield NHS Foundation Trust
Central and North West London NHS Foundation Trust

The Royal Borough of Kensington and Chelsea



THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

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

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1.0 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 concerns¹.
- 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 staff² 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 procedures³. 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 and monitor and review the use of the protocol.
- 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.
- 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.
- 1.7 ***Cases of single category/grade 1 and 2 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.***
- 1.8 The person should be referred to Social Services through local arrangements if there is:-
 - Significant skin damage (i.e. Category/ grade 3 or 4, unstageable ulceration or multiple grade 2) and
 - There are reasonable grounds to suspect that it was preventable or

¹ Statement of Government Policy on Adult Safeguarding May 2013

² The term staff is used to refer to employees from all sectors.

³ Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse – SCIE report 39-2011

- Inadequate measures taken to prevent development of pressure ulcer⁴, or
- Inadequate evidence to demonstrate the above

- 1.9 Significant damage in the case of a pressure ulcer is indicated by multiple pressure ulcers of category/grade 2 or a category/grade 3 or 4, as defined by the European Pressure Ulcer Advisory Panel (EPUAP) classification system.
- 1.10 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.
- 1.11 Where concerns are raised regarding skin damage there is a need to decide whether a safeguarding referral might be indicated as well as completing a clinical incident form. 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.
- 1.12 Any category/grade 2 and above pressure ulcer MUST be reported as a clinical incident according to local clinical governance procedures. It should be noted that all category/grade 3 and 4 pressure ulcers are reportable to NHS London as Serious Incident (SI).
- 1.13 Incipient pressure ulcers as recognised in NHS London Nurse Indicators which states:
- “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 category/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)
- 1.14 Therefore any category/grade 3 or 4 pressure ulcer identified within 72 hours of admission must be escalated and reported to the previous care provider as a clinical incidence.
- 1.15 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.

⁴ With reference to the NICE guideline 29 and local policies

2.0 Assessment Guidance

- 2.1 This is a multi agency protocol which provides guidance for staff⁵ who are concerned that a pressure ulcer may have arisen as a result of poor practice or neglect/abuse and therefore have to decide whether to make a referral via the PAN London Policy and Procedures⁶. The following provides guidance on whether to refer as a Safeguarding concern.
- 2.2 Assessment of the wound and completion of the decision guide must be completed by the first qualified member of staff who is a practicing registered nurse (RN), with experience in wound management and ideally not directly involved in the provision of care to the patient. This does not have to be a Tissue Viability Nurse.
- 2.3 In cases where the RN is not experienced in wound management, the examination and assessment must be completed by an RN who is competent or involve 2 members of staff. The second person could either be the line manager of the person who raises concerns, or 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 3. If further advice/support is needed with regards to making the decision to refer to the local authority, the Safeguarding Adults leads or Head of Safeguarding within the organisation should be contacted.
- 2.4 The safeguarding decision guide should be completed immediately or within **48 hours** of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension must be documented.
- 2.5 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 alert has been raised or the decision guide has been completed; if neither then an alert should be raised.
- 2.6 Following this, a decision should be made whether to make a safeguarding referral to Social Services in line with local referral arrangements.
- 2.7 The decision as to whether there should be a full investigation is made at the multi agency Safeguarding Adults Strategy Meeting, which could be a discussion by telephone. These strategy meetings are convened in response to individual cases. A summary of the strategy discussion should be recorded and shared with all agencies involved.
- 2.8 The strategy meeting may decide that health should complete a Root Cause Analysis or in the case of multi-agency care provision a full safeguarding investigation is required. Where a Root Cause Analysis is required this should be completed by the provider such

⁵ The term staff is used to refer to employees from all sectors.

⁶ Ibid

as District nurse team lead, ward manager or nursing home manager in line with the local policy e.g. pressure ulcer or risk management policies⁷.

- 2.9 The local authority need to decide/agree if post an Root Cause Analysis if a full case conference or virtual (telephone) case conference needs to be convened to agree finding, decide on safeguarding outcome and any actions.

3.0 Initial history taking and safeguarding decision guide completion

- 3.1 Before considering these 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 3). 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 grade 3/4/unstageable or multiple 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
 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/ grade 3 or 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 all of the 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?

⁷ 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)

- 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 4).
- 3.7 Documentation of the pressure ulcer must include site, size (centimetres) and category/grade. You must record your assessment on the Safeguarding Pressure Ulcer decision guide, see Appendix 3.
- 3.8 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:

Newcastle Safeguarding Adults Board: Safeguarding Adults and Skin Damage Protocol: Deciding whether to refer to the Newcastle Safeguarding Adults Procedures (23rd April 2009)

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)

- Department of Health (2003) Essence of care service user focused benchmarks for clinical governance April 2003
- National Institute for Health and Clinical Excellence (2005) Guidance for the prevention and treatment of pressure ulcers September 2005
- "Mental Capacity Act 2005 Code of Practice"

Accessible online:

<http://guidance.nice.org.uk/CG29>

- European pressure ulcer advisory panel Pressure Ulcer Treatment Guidelines (1998)

<http://www.epuap.org/qltreatment.html>

- Skin Changes at Life's End: Final Consensus Statement

APPENDIX 1: GUIDANCE FOR USE IN RISK ASSESSMENT

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
- Is the person receiving palliative 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 eg access or domestic/social arrangements⁸
- 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 monitoring? If so, did the person have the mental capacity to refuse such monitoring?⁹
- 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?

Expert advice on skin integrity

- Was appropriate assistance sought? E.g. professional advice from a Community Nurse Clinical Lead or Tissue Viability Specialist Nurse
- Was advice provided? If so was it followed?

Care planning & implementation for management of skin integrity

- Was a pressure ulcer risk assessment carried out and reviewed at appropriate intervals?

⁸ Family have no right to refuse monitoring

⁹ The person's consent to monitoring should always be sought, but if the person lacks the mental 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.

- If expert advice was provided did this inform 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?
- Was the specialist equipment used appropriately?
- Was the care plan revised within appropriate time scales?

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

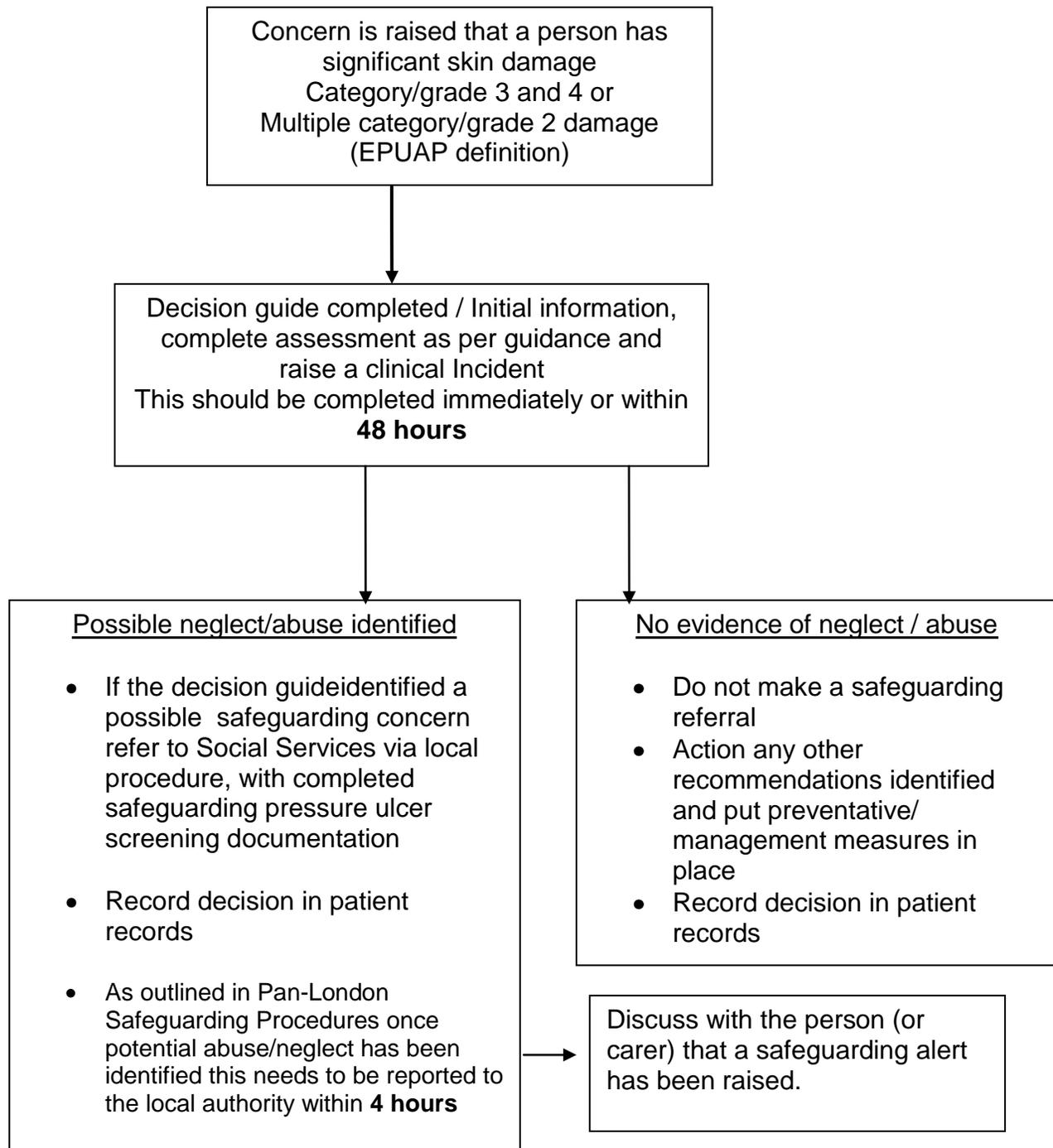
- Does the person have continence problems? If so are they being managed?
- Are skin hygiene needs being met? (including hair, nails and shaving)
- Has there been a deterioration in physical appearance?
- Are oral health care needs being met?
- Does the person look emaciated or dehydrated?
- Is there 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 flow chart – when to refer to Safeguarding Adult Procedures



APPENDIX 3

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/ grade of all pressure ulcer(s)			
Decision guide Score			
Summary/ rational for decision re safeguarding referral			
Safeguarding referral <input type="checkbox"/>			
Not for safeguarding referral <input type="checkbox"/>			

Adult Safeguarding Decision Guide for patients with pressure ulcers

Q	Risk Category	Level of Concern	Score	Evidence
1	Has the patient's skin deteriorated to either grade 3/4/unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/visit	Yes e.g record of blanching / non-blanching erythema / grade 2 progressing to grade 2 or more	5	
		No e..g. no previous skin integrity issues or no previous contact health or social care services	0	
2	Has there been a recent change, 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	
3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	0	State date of assessment Risk tool used Score / Risk level
		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	What elements of care plan are in place
		No or incomplete risk assessment and/or care plan carried out	15	What elements would have been expected to be in place but were not
4	Is there a concern that the Pressure Ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services	No / Not applicable	0	
		Yes	15	
5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk –Category/ grade 3 or 4 pressure ulcer	Skin damage less severe than patient's risk assessment suggests is proportional	0	
		Skin damage more severe than patient's risk assessment suggests is proportional	10	
6	Answer (a) if your patient has capacity to consent to every element of the care plan Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not 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	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				

If the score is 15 or over refer for Safeguarding by sending this form as your safeguarding referral to the relevant duty social worker.

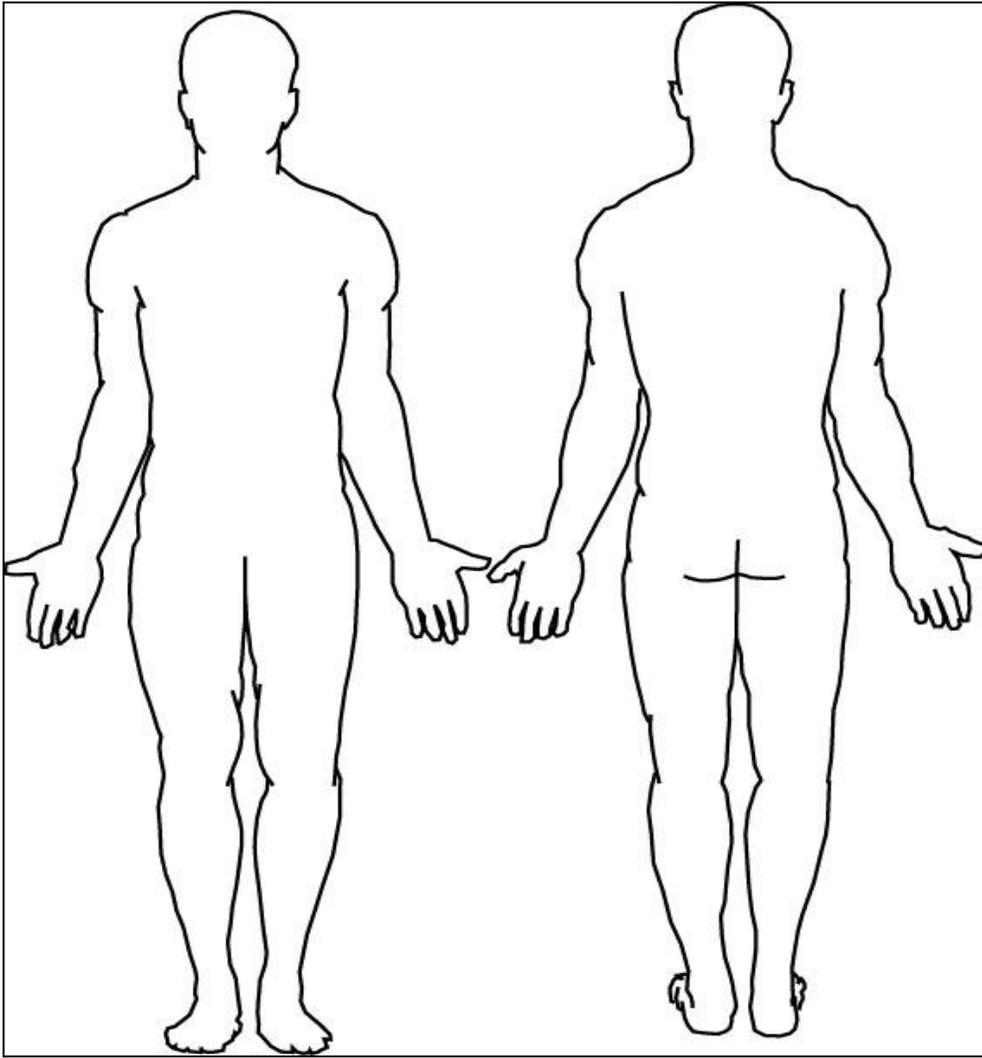
When the protocol has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the patient's notes

Patient Name: **Patient No:**.....

APPENDIX 4

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:.....