Trafford Safeguarding Adults Board

PROTOCOL FOR SAFEGUARDING ADULTS ENQUIRIES FOR PRESSURE ULCERS

Protocol for Safeguarding Adults Enquiries for Pressure Ulcers

Purpose

This guidance is designed to help practitioners who support adults where they may be concerns related to a Pressure Ulcer. Practical resources are included to help staff determine whether a pressure ulcer might have been caused by neglect or poor care, and if it warrants a safeguarding enquiry. It provides clear guidance for when to raise safeguarding concerns and make referrals to local authorities. The protocol aligns with the latest multiagency standards and clinical guidelines for pressure ulcer prevention and management.

Pressure Ulcers and Safeguarding

Safeguarding adults means protecting their right to live safely, free from abuse, neglect, or harm. It involves preventing and responding to any concerns about abuse or neglect.

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.

Pressure ulcers develop when the skin breaks down, often over bony areas. They can result from poor care, acts of omission, or neglect, but sometimes they are unavoidable despite best efforts. 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. It can also be due to poor multi-disciplinary team working for example where information is not recorded or shared in a timely way, or where there is a different understanding or grading of ulcers across agencies or professionals.

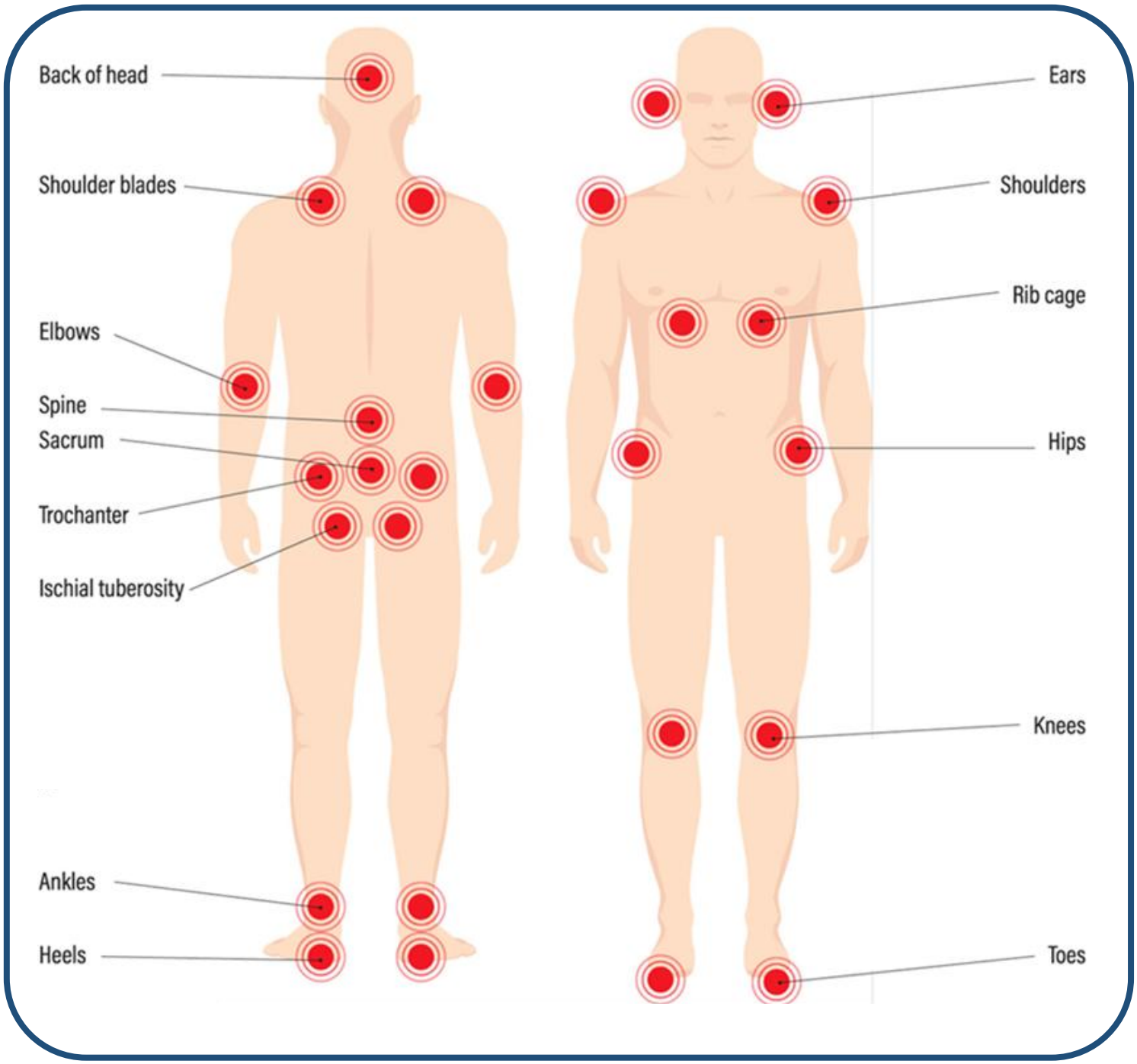
It is recognised that not all skin damage can be prevented and therefore the risk factors in each case should be reviewed on an individual basis before a safeguarding referral is considered.

Before deciding on a safeguarding referral, gather a full history, **including** contacting previous care providers if the person recently changed care settings.

Professionals should ensure that relevant and appropriate referrals are made for safe discharge and ongoing care and treatment, which may include, tissue viability referral, adult social care support on discharge and care plan and risk assessment review by care provider as a part of immediate protection planning.

Where a Safeguarding adults enquiry or Section 42 enquiry is taking place, any involved agencies safeguarding adults' team or lead should be made aware and engage and support the process.

Areas at risk of development of pressure ulcers



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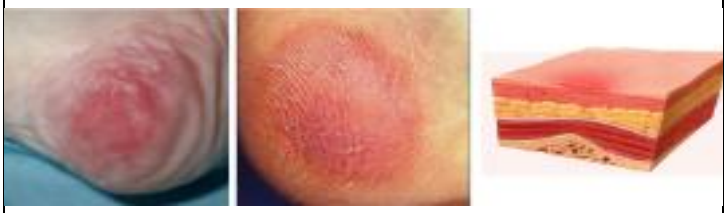
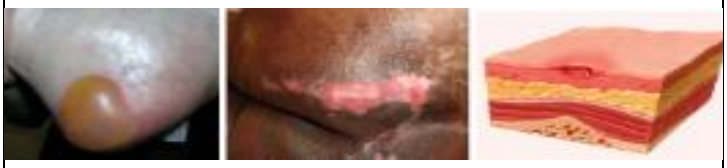
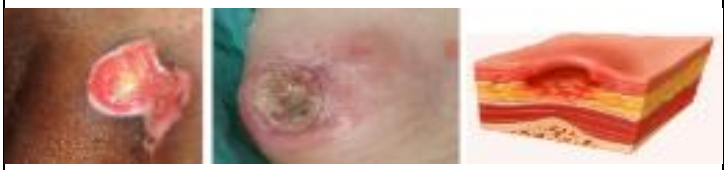
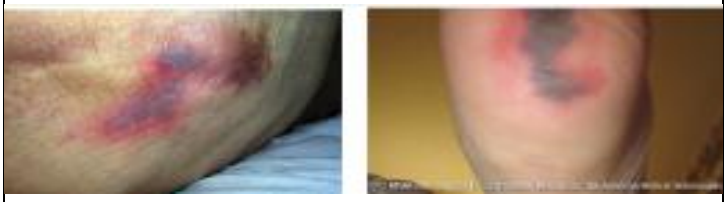
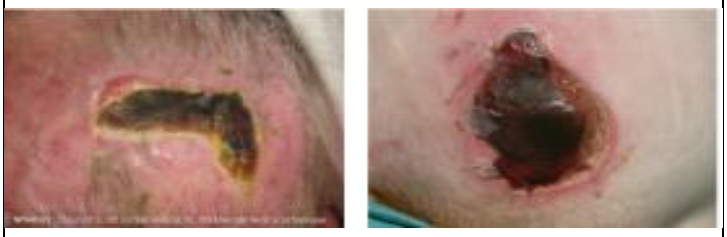
Grading Pressure Ulcers

Grading and Description	Supporting Images
Early Warning Signs - Blanching Erythema *Areas of discoloured tissue that blanch when fingertip pressure is applied and applied and the colour recovers when pressure released, indicating damage is starting to occur but can be reversed. On darkly pigmented skin blanching does not occur and changes to colour, temperature and texture of skin are the main indicators.*	
Grade 1- Non Blanchable Erythema *Intact skin with non-blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching, but the colour may differ from the surrounding area. The affected area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.*	
Grade 2- Partial Thickness Skin Loss *Loss of the epidermis/dermis presenting as a shadow open ulcer with a red/pink wound bed without slough or bruising. May also present as an intact or open/ruptured blister.*	
Grade 3- Full Thickness Skin Loss *Subcutaneous fat may be visible, but bone, tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunnelling.*	
Grade 4- Full Thickness Tissue Loss *Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunnelling.*	
Suspected Deep Tissue injury *Epidermis will be intact, but the affected area can appear purple or maroon or be a blood-filled blister over a dark wound bed. Over time this skin will degrade and develop into deeper tissue loss. Once grade can be established this must be documented.*	
Ungradable *Full thickness skin/ tissue loss where the depth of the ulcer is completely obscured by slough and/or necrotic tissue. Until enough slough and necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be Grade 3 or 4 once debrided. Once grade can be established this must be documented.*	
Combination Lesions *These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage as above, but awareness of other causes and treatments is needed. (See Excoriation & Moisture Related Skin Damage Tool)*	

Additional considerations

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 e.g. access or domestic/social arrangements?
- 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? Were any further measures taken to assist understanding e.g. person 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 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?
- 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

Assessment Tool:

Pressure Ulcer Threshold (for a safeguarding referral)

Pressure Ulcer Identified

Tissue Viability Nurses (TVN) or District nurses to determine category (ungradable, grade 2, grade 3, grade 4), body map and medical photos to be taken.

Complete Adult Safeguarding Decision Guide (ASDG) within 72 hours when:

- Ulcer was potentially avoidable.
- Inadequate prevention measures.

Score over 15 on ASDG:
A safeguarding adults concern should be raised to the local authority where the safeguarding concern is alleged to have occurred, including the decision guide and any photographs taken within the referral to the local authority. Continue with clinical care plan as per local Pressure Ulcer Policy.

Score under 15 on ASDG:
Save documents to patients notes. Continue with clinical care plan as per local Pressure Ulcer Policy.

Consider Mental Capacity
If the individual has been assessed as not having mental capacity to consent to any or some of the care plan it should be considered if appropriate care is undertaken in the individual's best interests?

Adult Safeguarding Decision Guide

Q	Risk Category	Level of Concern	Score	Evidence
1	Has the person's skin deteriorated to either category 3 or 4 or multiple sites of category 2 ulceration from healthy unbroken skin since the last opportunity to assess or visit?	**No** *(For example, no previous skin integrity issues or previous contact with health or social care services)*	0	
		Yes *(For example, record of blanching or non-blanching erythema progressing to category 2 or category 2 progression to category 3 or 4)*	5	
2	Has there been a recent change, that is 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, emergency hospital visit.*	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 an appropriate pressure ulcer care plan in place, and was this documented in line with the organisation's policy and guidance?	**Yes** Current risk assessment and care plan carried out by a healthcare professional and documented appropriate to person's needs. If the person is not under the care of the healthcare professional, the carer responsible has screened for risk and implemented preventative care accordingly.	0	
		Yes Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	State what parts of care plan that are in place
		No or Incomplete No or Incomplete Risk assessment and / or care plan	15	
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 or Not Applicable**	0	
		Yes	15	

5	Is the level of damage to skin inconsistent with the person's risk status for pressure ulcer development? *For example, no risk factors that align with the category of pressure ulcer that has developed*	Skin damage less severe than person's risk assessment suggests is proportional	0	
		Skin damage more severe than person's risk assessment suggests is proportional	10	
6	Question 6 has 2 parts- which part you ask depends on the person: • If the person has capacity to consent to every relevant element of the care plan, answer question 6a. • If the person has been assessed as not having mental capacity to consent to any or some relevant aspects of the care plan, answer 6b.			
6a	Were the risks and benefits explained and understood by the person? Was a plan of care agreed in line with shared decision making and has the person chosen to follow the relevant aspects of the plan?	Person has followed the care plan, and local policies to support shared decision making have been followed	0	
		Person followed some aspects of the care plan but not all	3	
		Person has not followed care plan or not given information to enable them to make an informed choice, or an opportunity to discuss reasons for not following the agreed plan and alter the plan accordingly has not been taken.	5	
6b	Was the relevant care undertaken in the person's best interests, following the best interest's checklist in the Mental Capacity Act? *This should be supported by documentation – for example, capacity and best interest statements and record of care delivered.*	Documentation of care being undertaken in person's best interests	0	
		No documentation of care being undertaken in person's best interests	10	
Total Score				

Score Conclusion

If the total 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 stored in the person's notes.

References

Care Act 2014 c. 23. Available at: Care Act 2014 (legislation.gov.uk). [Last accessed 4 Th October 2024].

Department of Health and Social Care, 2024. Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern. Available at: Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK (www.gov.uk). [Last accessed 26 September 2024]

Department of Health, 2014. 'Care and Support statutory guidance; Issued under Care Act 2014', London: Department of Health. Available at: Care and support statutory guidance - GOV.UK (www.gov.uk) [Last accessed 4th October 2024]

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel, 2019. Clinical Practice Guideline and Quick Reference Guideline. Available at: 2019 Guideline — International Guideline [Last accessed 22nd October 2024]

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