

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

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

### **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 concerns<sup>1</sup>.
- 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 concern.
- 1.3 The protocol provides guidance for staff<sup>2</sup> 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 Berkshire policy and procedures<sup>3</sup>. A pathway and flow diagram outlining the key elements of the protocol can be found in Appendix 5.1 and 5.2.
- 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 Safeguarding through local arrangements if there is:-

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<sup>1</sup> Statement of Government Policy on Adult Safeguarding May 2013

<sup>2</sup> The term staff is used to refer to employees from all sectors.

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

- 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

- Inadequate measures taken to prevent development of pressure ulcer<sup>4</sup>, or inadequate evidence to demonstrate the above.

1.9 Significant skin damage in the case of a pressure ulcer is indicated by 2 or more pressure ulcers of category/grade 2 or 1 or more 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 Patient's consent should be attempted, information should also be gathered from family and patient, to obtain a history of the problem. It is good practice to 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. There are also requirements for providers to report category/grade 3 or 4 to the appropriate governing body, CCG (for NHS) and CQC (for Care homes) Please check the requirements criteria for reporting and learning for your own organisations.

1.13 Any category/grade 3 or 4 pressure ulcer identified within 72 hours of admission to a unit or service must be escalated and reported to the previous care provider as a clinical incident.

1.14 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.

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<sup>4</sup> 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 staff<sup>5</sup> 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 Berkshire Safeguarding Policy and Procedures<sup>6</sup>. 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. **This does not have to be a Tissue Viability Nurse.**
- 2.3 This outcome of the decision guide must be documented on the report form in Appendix 5.3 or locally agreed referral form. If further advice/support is needed with regards to making the decision to refer to the local authority, the Safeguarding Adults leads within the Local Authority or provider organisation should be contacted.
- 2.4 The safeguarding decision guide should be completed immediately or as soon as reasonably possible following identification of 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 with significant skin damage may not be possible to complete the decision guide without additional information. As far as reasonably possible contact should be made with the transferring organisation to ascertain if the decision guide has been completed; if not, it should be completed jointly or an agreement about which agency should complete it. The decision form/tool should be completed by all providers for inherited or developed pressure ulcers appendix 5.3a is record and should be completed for all inherited and developed pressure ulcers. In the event of this not being agreed or any concerns a referral to safeguarding should be made to assess any unmet need or for Local authority /social care to obtain a providers response.
- 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 where a decision to refer is made to safeguarding Authority Safeguarding team should request that the provider to complete a Root Cause Analysis (RCA) or provide a response record to support the care and treatment decision making to evidence good safe appropriate care. In cases where the reported concern is from a third party the RCA/ report should be completed by the provider where the concern has allegedly occurred and the provider responsible for care at that time. *Guidance on what the RCA should consider is available in Appendix 5.5. This should be completed by a Senior Manager at the provider such as, Ward Manager or Residential/Nursing Home manager.*

- 2.8 In cases open to District Nursing Services or NHS Hospitals the development of a category 3 or 4 will trigger the Serious Incident Requiring Investigation (SIRI) process in line with the local policies e.g. pressure ulcer or risk management policies<sup>7</sup>.
- 2.9 SIRI processes will only look at the care delivered by NHS service; if the individual was receiving additional care through a residential or private homecare provider they should provide their own report/ RCA at the request of the LA under safeguarding.
- 2.10 The local authority need to decide/agree post Root Cause Analysis/SIRI, if a full Strategy Meeting or virtual (telephone) Strategy Meeting needs to be convened to agree findings, decide on safeguarding outcome and any actions.

### **3.0 Initial history taking and safeguarding decision guide completion**

The assessment must consider six key questions:

- 3.1 The six questions together indicate a safeguarding decision guide score (use Appendix 5.3a to record your score and decision appendix 5.3b gives further guidance to consider as to how to conduct the decision guide process).
- 3.2 The threshold for referral is 15 or above.  
**However this should not replace professional judgement.**
- 3.3 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.
- 3.4 It is **not** a tool to risk assess for the development of pressure damage.
- 3.5 Consent for photographic evidence needs to be sought as per local policy. Photographic evidence to support the report needs to be provided wherever possible.
- Photographic evidence is best practice however in the absence of this 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 5.4)
- 3.6 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. An downloadable form is available see end of policy for word version (Appendix 5.3a).

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<sup>5</sup> The term staff is used to refer to employees from all sectors.

<sup>6</sup> Ibid

<sup>7</sup> NHS England (London Region) Principles of Best Practice in Safeguarding and Pressure Ulcer reporting-2014

## **4.0 Kennedy Ulcers**

- 4.1** The skin is the largest organ of the body, and is subject to failure like an organ is when the body is dying. This is described as a Kennedy ulcer. Kennedy ulcers are rarer pressure ulcers that some individuals develop during the last hours of life. They are usually shaped like a pear, butterfly or horseshoe, and are located on the coccyx or sacrum area. The ulcers are a variety of colours including red, yellow or black and are sudden in onset, typically deteriorate rapidly, and usually indicate that death is imminent.
- 4.2** Pressure ulcers that develop in patients who have terminal illness or are the end of life should be assessed and staged as pressure ulcers.
- 4.3** A Kennedy ulcer would be deemed 'unavoidable' if it occurs as part of the dying process. It is expected though, that the usual investigation in line with local policies and procedures are followed to ensure best practice. The investigation must be recorded.

## **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 (23 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(30 November 2007)

[http://www.haringey.gov.uk/sites/haringeygovuk/files/haringey\\_ccg\\_pressure\\_ulcer\\_protocol\\_june\\_2015.pdf](http://www.haringey.gov.uk/sites/haringeygovuk/files/haringey_ccg_pressure_ulcer_protocol_june_2015.pdf) (accessed 02.03.17)

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 (2014)  
<http://www.epuap.org/qltreatment.html>

Skin Changes at Life's End: Final Consensus Statement  
<http://www.epuap.org/qltreatment.html>

# Appendix 5.1– Decision Pathway – Pressure Ulcers and safeguarding Adults (A3 format)

**PROMPT Duty of candour.**  
Contacting patient and family being open, honest and transparent about investigation ( Regulation 20 CQC)

Pressure ulcer is observed. Concern is raised that a person has significant skin damage. Category / Grade 3 and 4 or Multiple Category / Grade 2 damage (EPUAP definition.)

There need only be “reasonable cause to suspect,” you do not have to be certain.

PROMPT use the form/tool appendix 5.3 to help you may not know if patient is transferred from home or another

Are there concerns about abuse or neglect or the risk of these?

Apply the Berkshire Safeguarding Adults Pressure Ulcer Protocol

Need for Safeguarding Adults referral indicated?

Referral to safeguarding completed as per Trust policy

Local Authority, in partnership with the Trust and others, will determine whether a Safeguarding Enquiry is required

Safeguarding Enquiry?

Safeguarding Enquiry process takes place. The Local Authority, in consultation with the providers will determine who will contribute, including SI / RCA and agree time

The Local Authority, in consultation with the Trust and others as required, will decide whether actions should be taken and if so what and by whom

Actions carried out

Refer to SAB Guidance for a SAR. Is a SAR indicated?

Make recommendation to SAB for a Safeguarding Adults Review

SAB decision

Complete

Good recording should refer to evidence of the pressure damage being avoidable or lapse in care or unavoidable or appropriate care given pressure to be considered

Follow and record investigation record or SI RCA investigation process

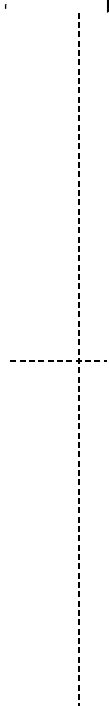
RCA identified recommendations shared for learning

Safeguarding referral indicated?

End

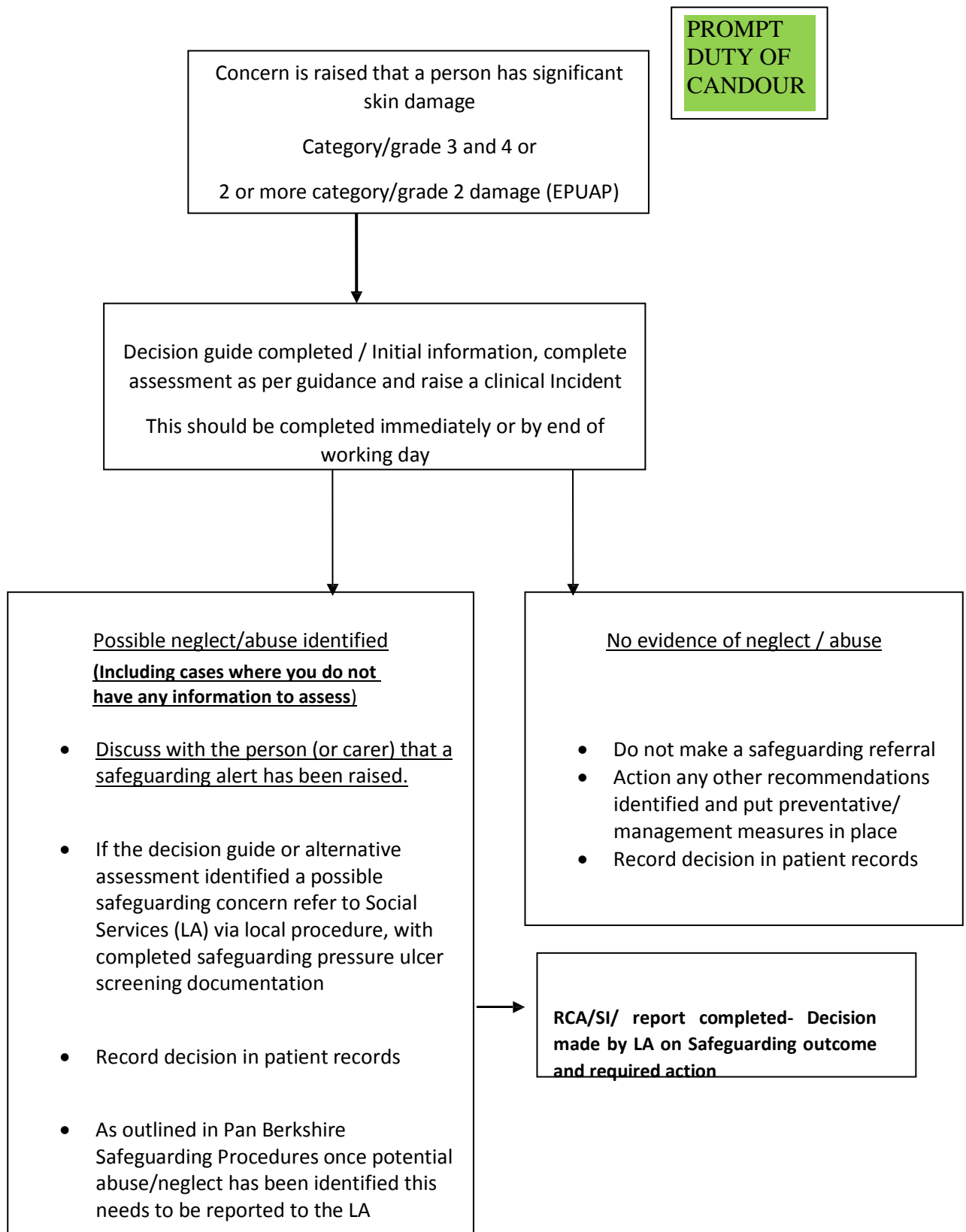
The SI / RCA is to be completed within 60 days or less criteria for SI reporting is met

- ABBREVIATIONS**
- PU - Pressure Ulcer
  - RCA -Root Cause Analysis
  - SAB - Safeguarding Adults Board
  - SAR – Safeguarding Adults Review
  - SI - Serious Incident



## Appendix 5.2

### Decision flow chart – When to refer to Safeguarding Adult Procedures





**Appendix 5.3: Adult Safeguarding Decision Guide for patients with pressure ulcers**  
**If the score is 15 or over refer for Safeguarding by sending this form with your safeguarding referral**

<p>The threshold for referral is 15 or above.  <b>However this should not replace professional judgement and recording in relation to cases that come into your service.</b></p>
<p>Patient has been transferred into the care of the organisation or admitted from home to your case load with significant damage and it was not possible to ascertain any information or jointly assess using the decision guide</p> <p>Referral to safeguarding adults has been made by ..... Date</p>
<p>A decision guide or information to support the decision guide has been shared across the providers between .....<b>( insert names and agencies)</b> and based on this information select option below</p> <p>A) No Safeguarding referral has been made to the LA</p> <p>B) The previous care provider has confirmed they have made a safeguarding referral</p>

**Patient name** ..... **Patient No**

	Risk Category	Level of Concern	Score	Evidence
<b>1</b>		Progressive onset / deterioration of skin integrity	<b>5</b>	
		Sudden onset / deterioration of skin integrity with a clinical reason explanation (if a lapse in care grade above)	<b>0</b>	
<b>2</b>	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)	Change in condition contributing to skin damage	<b>0</b>	
		No change in condition that could contribute to skin damage	<b>5</b>	
<b>3</b>	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 If this is a new pressure ulcer an appropriate pressure ulcer care plan would not be in place. A risk assessment would be	Current risk assessment and care plan carried out by health care professional and documented appropriate to patient needs	<b>0</b>	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 needs have changed	<b>5</b>	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 <b>THIS IS SAFEGUARDING</b>
<b>4</b>	Is there a concern that the Pressure Ulcer developed as a result of the informal carer wilfully ignoring or preventing across to	No /Not Applicable	0	
		Yes	15	

	care or services			
<b>5</b>	Is the level of damage to the skin inconsistent with the patient's risk status for pressure ulcer development? e.g low risk category /grade3 or 4 pressure ulcer	Skin damage less severe than patient risk assessment suggests is proportional	0	
		Skin damage more severe than patient's risk assessment suggests is proportional	10	
<b>6</b>	<b>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 ant part of the care plan or some capacity to consent to some but not all.</b>			
<b>a</b>	Was the patient compliant with the care plan having received information regarding the risk of non- compliance and documented they been explained	Patient not compliant with care plan (BHFT staff use non concordance forms)	0	
		Patient compliant with some aspect 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>b</b>	Was appropriate care undertaken in the patient's best interests, following the best interest's 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 best interest	0	
		No documentation of care being undertaken in the patients best interest	10	
<b>Total</b>				

**Completed by:**

**Date:**

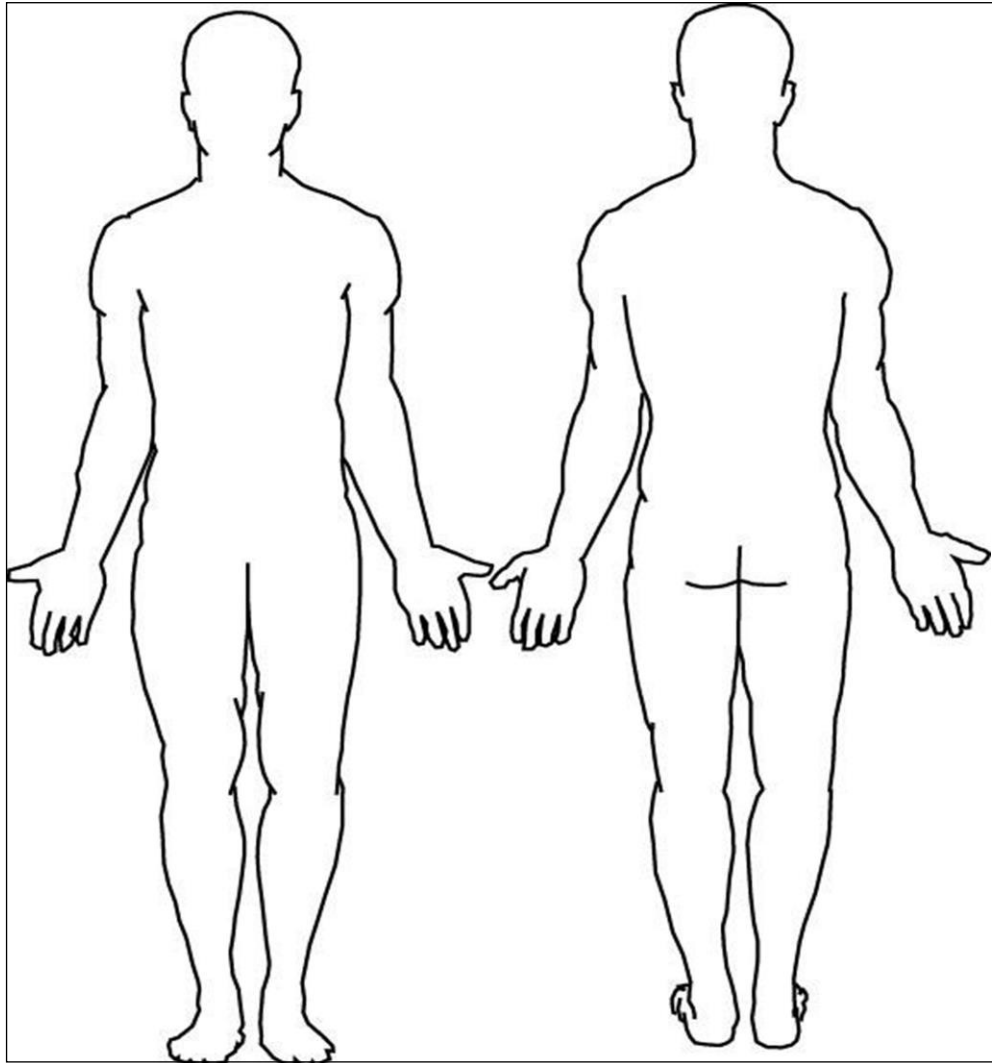
**Circle decision below:**

**Safeguarding Referral done**

**Not for Safeguarding Referral**

### Appendix 5.4: 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:**.....

## Appendix 5.5: GUIDANCE FOR USE IN ROOT CAUSE ANALYSIS

### 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. 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?
- 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?