**Common safeguarding issues – Pressure Ulcers**

This guidance is designed to help you address issues relating to the development of Pressure Ulcers and understand your responsibilities in reporting concerns when appropriate. The guidance is based on the principle that, "The best way of improving reporting and reducing error rates is to target the underlying systems failures rather than take action against individual members of staff" *(National Patient Safety Agency 2014)* and recommends the adoption of theSeven steps to patient safety:

|  |  |
| --- | --- |
| **Step 1** | **Build a safety culture**  Create a culture that is open and fair |
| **Step 2** | **Lead and support your staff**  Establish a clear and strong focus on patient safety throughout your organisation |
| **Step 3** | **Integrate your risk management activity**  Develop systems and processes to manage your risks and identify and assess things that could go wrong |
| **Step 4** | **Promote reporting**  Ensure your staff can easily report incidents locally and nationally |
| **Step 5** | **Involve and communicate with patients and the public**  Develop ways to communicate openly with and listen to patients |
| **Step 6** | **Learn and share safety lessons**  Encourage staff to use root cause analysis to learn how and why incidents happen |
| **Step 7** | **Implement solutions to prevent harm**  Embed lessons through changes to practice, processes or systems |

National Patient Safety Agency (July 2004)

**How might Pressure ulcers be a safeguarding issue?**

Many people who are frail and have restricted mobility are at risk of developing sores on the points of their body which receive the most pressure. These are known as pressure sores and are sometimes called bed sores or ulcers. Pressure sores start with skin discoloration but, if left untreated, they can become very deep and infected; in the worst cases they can be life threatening. With management and care, pressure sores can be avoided in most cases (some estimates suggest as high as 95%).

Whilst not all pressure sore are due to neglect (whether deliberate or unintentional) each individual case should be considered, taking into account the person's medical condition, prognosis, any skin conditions and their own views on their care and treatment. These things, rather than the grading of the pressure sore, should determine whether a safeguarding referral is appropriate. Other signs of neglect, such as poor personal hygiene and living environment, poor nutrition and hydration may help to influence this decision.

**Prevention checklist**

* All care staff receive training on how to prevent pressure sores and how to identify the early stages.
* All residents/clients are regularly assessed on the risk of developing pressure sores.
* Individuals at risk of developing bed sores are assessed/ referred for assessment for appropriate equipment and it is provided promptly.
* Key people in the organisation are trained in pressure sore care.
* Staff make timely referrals to, and receive prompt support from, community health professionals in pressure sore management.
* Body maps are completed to identify and monitor any current pressure sores.
* Managers regularly review pressure sore care and develop action plans, including identifying training, where needed
* All care plans are reviewed regularly and accurate reflect the persons current needs and the care provided

**When is a pressure sore notifiable under the Oxfordshire Safeguarding Adults Procedures**

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[[1]](#footnote-1).

This guidance 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.

The document provides guidance for staff 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 Oxfordshire Safeguarding policy and procedures.

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.

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.

*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.*

The person should be referred to Social Services through local arrangements if there is:-

1. 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[[2]](#footnote-2), or inadequate evidence to demonstrate the above.
2. 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.

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.

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.

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).

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)

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.

Staff should also refer to:

1. their own organisation’s policies and procedures on pressure ulcers
2. other relevant local and national guidelines, protocols and policies e.g. NICE Guidance, incident reporting policies.

**Threshold of Needs Matrix**

**Guidance:** This tool does not replace professional judgement or aim to set a rigid threshold for intervention. It helps you consider the type and seriousness of abuse and the circumstances in which a referral to adult social care may be required.

| Types of abuse and  seriousness | Levels of harm and related indicators/examples | | | |
| --- | --- | --- | --- | --- |
| Level | Lower Level Harm  Incidents meeting the lower level criteria should, wherever possible, be addressed at a local level with the individuals concerned with particular attention to preventing reoccurrences. | | Significant Very significant Harm  Likely to meet threshold for Section 42 enquiry | Critical  Serious criminal matter – Immediate discussion with police required. Likely to result in urgent request for s.42 enquiry | |
| Pressure Ulcers | * Single or isolated incident of Grade 1 or 2 pressure ulcer | * Grade 3 & 4, Unstageable and SDTI pressure ulcers or multiple grade 2 pressure ulcers where: * Documentation and equipment are available to demonstrate full assessment and review is complete, has been fully complied with and/or care plan has been developed and implemented, and * Evidence available to show concerns were raised and support was sought from a relevant professional, and * Evidence suggests that this is an isolated incident | * Grade 3 & 4, Unstageable and SDTI pressure ulcers or multiple grade 2 pressure ulcers where: * Documentation demonstrates that assessment and review has been completed but the care plan has NOT been fully implemented. * Evidence is NOT CLEAR that concerns were raised or support sought at the appropriate time. e.g. where knowledge / skills have been lacking; wound not responding to treatment. * There have been other similar incidents or areas of concern. | * Grade 4, Unstageable and SDTI AND other issues of significant concern * Assessed as NOT having mental capacity and treatment and prevention NOT provided. * Poor or no documentation is available to demonstrate that a full assessment has been completed or that the care plan and general care regime (e.g. nutrition, hydration) have NOT been developed and NOT been implemented – Is a CONCERN * No support sought. * Evidence demonstrates this is part of a pattern or trend in that clinical area. If this is not known, a discussion with the Lead for Safeguarding must take place. | |
| The person has mental capacity and has refused treatment and prevention strategies.  Only exceptional cases of self-neglect will trigger adult safeguarding. All standard interventions must be used first to manage risk e.g. Care Management/Care Plan Approach/Multi-Disciplinary Team, providing:   1. A clear capacity assessment is in place 2. Evidence available to show concerns were raised and support was sought from a relevant professional | |

**Haringey CCG Adult Safeguarding Decision Guide for patients with pressure ulcers**

**GUIDANCE FOR USE WITH THE SAFEGUARDING Decision Guide (see below))**

The safeguarding decision guide should be completed immediately or within **24 hours** of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension must be documented.

Following this, a decision should be made whether to make a safeguarding referral to Social Services. For patients who score less than 15 on the decision making tool a safeguarding referral will not be required, however, patients who score 15 and above, this should be automatically referred. It should be noted that the score does not preclude clinical judgement. If the assessor feels there is an element of doubt then the patient should be referred to safeguarding even if the score is below 15.

**Structure for assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Q** | **Risk Category** | **Level of Concern** | **Score** | **Evidence** |
|  | Has there been an unexpected deterioration in the patient’s skin integrity from the last opportunity to assess? | Progressive onset / deterioration of skin integrity | 5 |  |
| Sudden onset / deterioration of skin integrity | 0 |  |
|  | 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 | Change in condition contributing to skin damage | 0 |  |
| No change in condition that could contribute to skin damage | 5 |  |
|  | 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 |
|  | 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 |  |
|  | 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 |  |
|  | 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** | | |  |  |

Patient Name:………………………………………………… Patient No:……………………………………………………..

Safeguarding Referral  Not for Safeguarding referral

**GUIDANCE FOR USE WITH THE SAFEGUARDING Decision Guide Structure for assessment**

**History**

Include any factors associated with the person's behaviour that should be taken into consideration:

Click here to enter text.

**Medical history**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the person have a long term condition which may impact on skin integrity; such as Rheumatoid Arthritis | Yes |  | No |  |
| Is the person receiving palliative care? | Yes |  | No |  |
| Does the person have any mental health problems or cognitive impairment which might impact on skin integrity? e.g. dementia / depression | Yes |  | No |  |

**Monitoring of skin integrity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Were there any barriers to monitoring or providing care e.g. access or domestic/social arrangements | Yes |  | No |  |
| 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) | Yes |  | No |  |
| Did the person refuse monitoring? If so, did the person have the mental capacity to refuse such monitoring?7 | Yes |  | No |  |
| 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? | Yes |  | No |  |
| If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time? | Yes |  | No |  |

**Expert advice on skin integrity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Was appropriate assistance sought? E.g. professional advice from a District Nurse or Tissue Viability Specialist Nurse | Yes |  | No |  |
| Was advice provided? If so was it followed? | Yes |  | No |  |

**Care planning & implementation for management of skin integrity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Was a pressure ulcer risk assessment carried out and reviewed at appropriate intervals? | Yes |  | No |  |
| If expert advice was provided did this inform the care plan? | Yes |  | No |  |
| 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? | Yes |  | No |  |
| 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? | Yes |  | No |  |
| Was the specialist equipment provided in a timely manner? | Yes |  | No |  |
| Was the specialist equipment used appropriately? | Yes |  | No |  |
| Was the care plan revised within appropriate time scales? | Yes |  | No |  |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the person have continence problems? If so are they being managed? | Yes |  | No |  |
| Are skin hygiene needs being met? (including hair, nails and shaving) | Yes |  | No |  |
| Has there been deterioration in physical appearance? | Yes |  | No |  |
| Are oral health care needs being met? | Yes |  | No |  |
| Does the person look emaciated or dehydrated? | Yes |  | No |  |
| Is there evidence of intake monitoring (food and fluids)? | Yes |  | No |  |
| Has patient lost weight recently? If so, is person's weight being monitored? | Yes |  | No |  |
| Are they receiving sedation? If so is the frequency and level of sedation appropriate? | Yes |  | No |  |
| Do they have pain? If so has it been assessed? Is it being managed appropriately? | Yes |  | No |  |

**Other possible contributory factors**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Has there been a recent change (or changes) in care setting? | Yes |  | No |  |
| Is there a history of falls? If so has this caused skin damage? Has the person been on the floor for extended periods? | Yes |  | No |  |

Adapted from Policy for Managing and Supporting Staff Following a Medication Error (Worcestershire PCT

1. Statement of Government Policy on Adult Safeguarding May 2013 [↑](#footnote-ref-1)
2. With reference to the NICE guidelines [CG179] and local policies [↑](#footnote-ref-2)