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HSAB Summary of Department of Health and Social Care Guidance

**Safeguarding adults’ protocol: pressure ulcers and raising a safeguarding concern**

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Some causes of skin damage relate to the individual person, including factors such as the person’s medical condition, nutrition and hydration. External factors may contribute to this, including:

*• poor care*

*• poor communication between carers and nurses*

*• ineffective multi-disciplinary team working*

*• lack of access to appropriate resources such as equipment and staffing*

When advising an individual who has capacity about self-care and

prevention of pressure ulcers, it is important to establish that the person:

*• has understood the advice*

*• can put the advice into practice*

*• has any necessary equipment and knows how to use it*

*• understands the implications of not following the advice*

Where it appears that the individual is neglectful in caring for themselves or the environment, **staff should seek further advice from their safeguarding lead.**

It is recognised that **not all pressure ulcers can be prevented** and the risk factors for each person should be looked at on an individual basis and an appropriate care plan put in place that is regularly and frequently reviewed.

**Background**

Pressure ulcers may occur as a result of neglect. Neglect may involve the deliberate withholding or unintentional failure of a paid, or unpaid, carer to provide appropriate and adequate care and support. Neglect and acts of omission include:

* ignoring medical, emotional or physical care needs
* failure to provide access to appropriate healthcare and support or educational services.
* the withholding of the necessities of life, such as medication, adequate nutrition and heating
* In some instances, this is highly likely to result in significant preventable skin damage.

Where unintentional neglect may be due to an unpaid carer struggling to provide care, an appropriate response would be to revise the package of care and ensure that the carer has the support and equipment to care safely. In these circumstances it can be highly distressing to talk to carers about abuse and neglect, particularly where they have been dedicated in providing care but have not been given advice and support to prevent pressure ulcers.

Skin damage has a number of causes. Pressure ulcers are caused by sustained pressure, including pressure associated with shear, where the person’s individual tissue tolerance and susceptibility to pressure has been overcome. External shear forces occur due to movement of the skin surface relative to a supporting surface, such as when an individual slides down the bed when in a semi-recumbent sitting position. This results in distortion of the soft tissue layers, including the blood vessels. Shear commonly occurs at the sacrum and heels. Internal shear forces can occur within the soft tissue layers due to both compression and shear forces.

Categories

Single cases of category (or grade) 1 and 2 pressure ulcers must be considered as requiring early intervention to prevent further deterioration or damage. If a professional has concerns regarding poor practice, they must ensure appropriate escalation through internal and local authority reporting systems.

Severe damage in the case of pressure ulcers is indicated by:

* multiple pressure ulcers of category (or grade) 2
* a single case of category (or grade) 3 or 4 (to include unstageable and suspected deep tissue injury)

It is recognised that severe pressure ulcer damage can already be present and yet not visible on the skin. These are known as incipient pressure ulcers.

All levels of skin damage as a result of pressure or shear, or a combination of both, must be reported through well-understood local reporting systems that have been agreed by all partners and endorsed by the SAB and QSG.

Skin damage that is established to be as a result of incontinence and/or moisture alone should not be recorded in the notes as a pressure ulcer but should be referred to as a moisture lesion to distinguish it and recorded separately. However, where this might be as a result of neglect or poor oversight it should be explored not ignored.

A lesion that has been determined as combined, that is, caused by both moisture and pressure, must be recorded in the notes as a pressure ulcer.

Skin damage that is determined to be as a result of pressure from a device, such as from casts or ventilator tubing and masks, must be recorded as pressure damage. These are known as device related pressure ulcers.

The decision guide **(appendix 1 - on the**[**Pressure ulcers: how to safeguard adults**](https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults)**page: link at the end of this guidance)** should be completed by a qualified member of staff who is a practising registered nurse (RN) with experience in wound management and not directly involved in the provision of care to the service user.

**This does not have to be a tissue viability nurse.**

The adult 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 should be recorded.

The outcome of the assessment should be documented on the **adult safeguarding decision guide**. If further advice or support is needed with regards to making the decision to raise a concern to the local authority, the safeguarding adults lead or the next most senior manager within the organisation should be contacted. For example, this might be an executive nurse in a health setting. In acute setting the decision regarding the concern is made after contacting the safeguarding team and discussion with the matron and /or lead nurse.

Following this, a decision should be made whether to raise a safeguarding adults concern with the local authority, in line with agreed local arrangements.

The decision as to whether there should be a section 42 enquiry will be taken by the local authority, and this will be informed by a clinical view. **A summary of the decision should be recorded and shared with all agencies involved.**

Where an internal investigation is required, this should be completed by the organisation that is taking care of the individual, such as the district nurse team lead, ward manager or care / nursing home manager, in line with the local policies, such as pressure ulcer or risk management policies.

The local authority needs to decide or agree after completion of the internal investigation if a full s.42 enquiry needs to take place and if required a Safeguarding Strategy Meeting.

The safeguarding decision guide assessment considers 6 important questions that together indicate a safeguarding decision guide score. This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the pressure ulceration. It is not a tool to risk assess for the development of pressure damage.

#### **If there is a safeguarding concern**

Where the score is **15 or higher**, or where professional judgement determines safeguarding concerns, a copy of the completed decision guide, along with a completed adult safeguarding concern proforma regarding pressure ulceration (appendix 3 - on the [Pressure ulcers: how to safeguard adults](https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults) page), should then be sent to the adult safeguarding team within the local authority. Copies of both should also be retained in the service user’s electronic or paper notes.

Where there is no indication that a safeguarding concern needs to be raised the completed decision guide should be retained in the service user’s notes.

**Adult Safeguarding Decision Guide**

**Adult Safeguarding Decision Guide**

The threshold for raising a concern is **15 or above**. However, this should not replace professional judgement. The questions and scores are outlined in appendices 1, 2 and 3 which provide the full decision-making tool and recording document.

The 6 questions are:

1. Has the patient or service user’s skin deteriorated to either category 3, 4 or unstageable, or multiple sites of category 2 ulceration from healthy unbroken skin, since the last opportunity to assess or visit?
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 (skin changes at life end), critical illness.
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?
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 or service user’s risk status for pressure ulcer development? For example, low risk, category (or grade) 3 or 4 pressure ulcer.

Answer question 6a if the patient or service user has capacity to consent to every element of the care plan:

6a. Was the patient or service user able to follow the care plan having received clear information regarding the risks of not doing so?

Answer question 6b if the patient or service user has been assessed as not having mental capacity to consent to any or some of the care plan:

6b. Was appropriate care undertaken in the patient’s best interests, following the best interests checklist in the Mental Capacity Act Code of Practice? This should be supported by documentation, for example, capacity and best interest statements and record of care delivered.

Photographic evidence to support the report should be provided wherever possible. Consent for this should be sought as per local policy but great sensitivity and care must be taken to protect the individual.

A body map **(appendix 2 - on the**[**Pressure ulcers: how to safeguard adults**](https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults)**page or your own internal body map)** should be used to record skin damage and can be used as evidence, if necessary, at a later date. If 2 workers observed the skin damage, they should **both** sign the body map.

Documentation of the pressure ulcer should include:

* **site**
* **size - including its maximum length, width and depth (in centimetres)**
* **category (or grade)**

The assessment should be recorded using the adult safeguarding decision guide assessment.

**How to complete the Safeguarding Decision Guide**

Use the following criteria when completing the adult safeguarding decision guide for individuals with severe pressure ulcers.

**3. Monitoring of skin integrity**

Ask questions such as:

* Were there any barriers to monitoring or providing care - for example, access or domestic or 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 decline monitoring? If so, did the person have the mental capacity to decline such monitoring?
* Were any further measures taken to assist understanding? For example, patient or service user information, leaflets, escalation to clinical specialist, ward leads, team leader and senior nurses?
* Does the person require EASY READ documents? Have reasonable adjustments been considered, if the person has a learning disability/ difficulty or neurodiversity?
* If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?
* Were there any other notable personal or social factors which have affected the person’s needs being met? For example, history of self-neglect, lifestyle choices and patterns, substance misuse, unstable housing, faith, mental ill health, learning disability.

**2. Medical history**

Ask questions such as:

* Does the person have a long-term condition or take any medication which may impact on skin integrity? For example, rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), chronic oedema or steroid use.
* Is the person receiving end of life care?
* Does the person have any mental health problems or cognitive impairment which might impact on skin integrity? For example, dementia or depression.
* Does the person have poor nutritional intake?
* Is advanced dementia impacting on the person’s ability to process nutrition?

**1. History**

Include any factors associated with the person’s behaviour that should be taken into consideration - for example, sleeping in a chair rather than a bed.

#### **4. Expert advice on skin integrity**

Ask questions such as:

* Was appropriate assistance sought? For example, professional advice from a community nurse, clinical lead or tissue viability specialist nurse.
* Was advice provided? If so, was it followed?

#### **7. Other possible contributory factors**

Ask questions such as:

* 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?

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

Ask questions such as:

* 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 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 the person lost weight recently? If so, is the 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?
* Have all nursing care risk assessments been completed?

#### **5. Care planning and implementation for management of skin integrity**

Ask questions such as:

* Was a pressure ulcer risk assessment carried out upon entry into the service and reviewed at appropriate intervals?
* If expert advice was provided, did this inform the care plan?
* Did skin integrity assessment and monitoring at suitable and appropriate intervals form part of 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?
* If the person has been assessed as lacking mental 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 line with local timescales?
* Was the specialist equipment used appropriately?
* Was the care plan revised within time scales agreed locally?

*Thank you to Warrington Safeguarding Adults Board for sharing this easy read guidance.*

Click or Tap here for more information and to access the appendices.



### **Assessment score and next steps**

**If the decision guide score is 15 or higher (which is a concern for safeguarding), you should:**

* discuss with the person, family and/or carers that there are safeguarding concerns, explaining why and that a safeguarding enquiry has been raised.
* refer to local authority via local procedure, with completed safeguarding pressure ulcer decision guide documentation.
* follow local pressure ulcer reporting and investigating processes.
* record decision in person’s records.

**If the score is under 15, you should:**

* discuss with the person, family and/or carers and explain reason why not treating as a safeguarding enquiry.
* explain why it does not meet criteria for raising a safeguarding concern with the local authority, but then emphasise the actions which will be taken.
* action any other recommendations identified and put preventative or management measures in place.
* follow local pressure ulcer reporting and investigating processes.
* record decision in person’s records.