Information for staff

NHS
Berkshire Healthcare
NHS Foundation Trust

Pressure ulcers and Safeguarding

A learning brief

September 2022

Pressure ulcers have a number of causes, some relating to the individual person, such a refusal of care and/or equipment, 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's recognised that not all pressure ulcers can be prevented and therefore the risk factors in each case should be reviewed on an individual basis before raising a safeguarding concern is considered.

In regard to pressure care, neglect or acts of omission 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 pressure ulcers. Staff have a duty of care to report all cases of actual or suspected abuse and/or neglect through the safeguarding process.

This is a multi-agency pathway which aims to support decisions about appropriate responses to pressure ulcer care. It provides guidance for staff in all sectors who are concerned that a pressure ulcer may have arisen as a result of poor practice, abuse, self-neglect, neglect or acts of omission and therefore must decide whether to raise a safeguarding concern to the Local Authority.

This guidance is summarised here in this Learning Brief and can also be found online.

Cases of single category 1 or 2 pressure ulcers must be considered as requiring early intervention to prevent further damage. If there are concerns regarding poor practice, an appropriate intervention must be considered, i.e. raising a clinical incident.

The person is to be referred to safeguarding if:

- Significant pressure damage i.e. category 3 or 4, unstageable ulceration, deep tissue injury or multiple category 2, **and**
- There are reasonable grounds to suspect it was preventable, **or**
- Inadequate measures were taken to prevent development of pressure ulcer, **or**
- Inadequate evidence to demonstrate the above, **or**
- There are concerns about self-neglect

Any category 3,4, deep tissue or unstageable pressure ulcer identified at the first skin assessment of admission or start of service delivery must be escalated and reported to the previous care provider as a clinical incident if the previous care provider was delivering support that involved pressure care management.

It's best practice to discuss any concerns identified and the steps that are being taken with the person if this is appropriate.

When to refer to Safeguarding

Follow the flow chart below (Appendix 5.1)

Appendix 5.1 (extract from Berkshire safeguarding procedures)

Decision flow chart – When to raise a safeguarding concern in regards to pressure ulcers To be used in conjunction with Berkshire Safeguarding Adults Polices and Procedures

Where concerns are raised regarding pressure ulcers organisations are to follow their own internal procedures such as the completion of a clinical incident form as well as raising a safeguarding concern.

Concern in raised that a person has significant skin damage

Category 3 and 4, unstageable deep tissue injury or multiple category 2 damage

Duty of candour?

Regulatory reporting?

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Decision guide completed (appendix 5.2)/ initial information, complete assessment as per guidance.

This should be completed immediately or by end of working day

Possible neglect/abuse identified (Including cases where you do not have any information to assess)

- Where appropriate discuss with person (or carer) that a safeguarding alert has been raised
- If the decision guide or alternative assessment identified a possible safeguarding concern refer to Social Services (LA) via local procedure, with completed decision guide.
- Record decision and completed decision guide in persons records
- As outlined in the Berkshire Safeguarding Adults Policies and Procedures once potential abuse/neglect has been identified a safeguarding adults concern is to be raised.

↓

Decision made Safeguarding Adults Team on the concern outcome and required action

No evidence of neglect/abuse

- Do not raise a safeguarding concern
- Action any other recommendations identified and put preventative/ management measures in place
- Record decision and completed decision guide in persons records

Referrers should receive feedback on the concern raised from the Safeguarding Adults Team.

Using the Adult Safeguarding decision guide

Complete the Decision guide below and review the additional considerations questions below to help you.

The threshold for a safeguarding concern is 15 or above. However, this must not replace professional judgement. 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 ulcer(s).

The decision guide is not a tool to risk assess for the development of pressure damage.

What to do

- Where appropriate discuss with person (or carer) that a safeguarding alert has been raised
- If the decision guide or alternative assessment identified a possible safeguarding concern refer to Social Services (LA) by securely emailing your completed Datix, with completed decision guide
- Record decision and completed decision guide in persons records
- As outlined in the Berkshire Safeguarding Adults Policies and Procedures once potential abuse/neglect has been identified a safeguarding adults concern is to be raised.

The pathway should be completed immediately or within 24 hours following the identified of the pressure ulcer concern. In exceptional circumstances the timescale may be extended but the reasons for the extension must be documented.

Where the individual has been transferred into the care of an organisation with significant pressure damage the decision guide Appendix 5.2 is still to be completed. As far as is reasonably possible, contact should be made with the transferring organisation to ascertain if the decision guide has been completed and if not, it should be completed jointly, or an agreement made about which agency should complete it.

Management of the safeguarding concern in the Local Authority

On receipt of the safeguarding concern the Safeguarding Adults Team (SAT) will consider thresholds for a S42 enquiry and open the enquiry if thresholds are met.

The SAT will work with the organisation involved to seek assurances that lessons have been learnt, if assurance cannot be provided the SAT will consider if there is a systemic issue with the organisation. The concerns may be addressed through the following: S42 enquiries, care management pathways, care quality frameworks or risk management processes.

In cases open to Berkshire Healthcare services the development of a category 3,4, unstageable or deep tissue injury will trigger the Serious Incident Requiring Investigation (SIRI) process in line with local policies e.g. pressure ulcer or risk management policies. Safeguarding Adults Teams can request copies of SIRI's for its enquiries.

Adult Safeguarding Decision Guide

Appendix 5.2 (extract of pan safeguarding procedures)

When to raise a safeguarding concern in regard to pressure ulcers

If the score is 15 or over refer to the Safeguarding Adult Team by sending this form with your safeguarding concern.

The threshold for a safeguarding concern is 15 or above. However, this should not replace professional judgement and recording in relation to cases that come into your service.

When completing this decision guide please refer to Berkshire Safeguarding Adults Polices and Procedures

Person Name: …….. Person Reference Number:……

Decision Guide Questions

Transfer of care with pressure damage

Has the person been transferred into the care of the organisation or admitted from home to your service with significant damage and it was not possible to ascertain any information or jointly assess using the decision guide?

Yes ☐

No ☐

The decision guide or information to support the completion of the decision guide has been shared across the providers INSERT NAMES AND AGENCIES HERE and based on this information the following decision has been made:

No Safeguarding concern has been raised ☐

The previous care provider has confirmed they have raised a safeguarding concern ☐

Complete table overleaf and Attach body Map, Appendix 5.3

Completed By …… Date:……..

Outcome

Safeguarding concern to be raised ☐

Safeguarding concern not required ☐

	Risk Category	Level of Concern	Score	Evidence
1	Has there been an unexpected deterioration in the person's skin integrity from the last opportunity to assess?	Progressive onset / deterioration of skin integrity	5	
		Sudden onset / deterioration of skin integrity with a clinical reason explanation (if a lapse in care score 5 above)	0	
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)	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. 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	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 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 THIS IS SAFEGUARDING
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	THIS IS SAFEGUARDING
5	Is the level of damage to the skin inconsistent with the person's risk status for pressure ulcer development?	Skin damage less severe than person risk assessment suggests is proportional	0	
		Skin damage more severe than person's risk assessment suggests is proportional	10	
6	Answer (a) if the person has capacity to consent to every element of the care plan Answer (b) if the person 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.			
a	Was the person compliant with the care plan having received information regarding the risk of non- compliance and documented they been explained	Person not compliant with care plan	0	
		Person compliant with some aspect of care plan but not all	3	
		Person compliant with care plan or not given information to enable them to make an informed choice	5	
b	Was appropriate care undertaken in the person'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 person's best interest	0	
		No documentation of care being undertaken in the person's best interest	10	
Total				

Additional considerations and information to include:

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?

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 person 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.

Safeguarding and wound care: a structured approach to patient safety

Case study

- Mr X is an 89 year old male who lives with his son. He has been referred to the District Nurses (DN), for a dressing to a pressure ulcer that he sustained as a result of him contracting COVID-19. Since his illness, Mr X is finding it difficult to mobilise, and he has recently been refusing to eat. He has on several layers of clothing which appear soiled and unkempt.
- PMHx: Vascular Dementia/diabetic patient on insulin/THR (bi-lateral)
- He was assessed by the DN on his first visit, and had a very high WLS/Category 3 pressure ulcer to sacrum/MUST 3
- Unstageable PU to left heel
- Both Mr X and his son refuse to have pressure relieving cushion, or a dietitian referral. They also refuse a hospital bed and referral to a Community Matron because they do not want people in and out of their house.

The assessment

Asessment. Clearly Mr X has nutritional needs, as well as a need for him to have the right devices to minimise further skin damage such as pressure mattress/cushion

Skin- Mr X has skin damage, and with his current WLS and MUST, as well as his decreased mobility, is at risk of further skin damage.

Surface- With good clinical decision making, Mr X will need the right equipment to support with pressure relief

Keep moving- Mr X needs to be encouraged with mobilising, and we need to ascertain why his mobility is deteriorating

Incontinence- Mr X needs to be assessed to ensure he is not incontinent and that IAD/MASD is not an issue for him

Giving Information- Have we given Mr X and his son, the correct information to make an informed decision, ensuring that the patient understand the information, and any concerns about understanding should lead to a mental capacity assessment

Are we still concerned and where does safeguarding sit with wound care?

- If Mr X is at risk of neglect by his son, or we are unsure that this is the case, a safeguarding referral, could prevent further harm from occurring. (Berkshire Healthcare referral)
- Perhaps the family need further support with decision making, and the Trust Safeguarding Team can support with minimising further risk of harm for Mr X by referring to Berkshire Healthcare Safeguarding team
- Making necessary referrals to other services to LA
- Ensuring adequate support is put in place to support MR X and his son, including financial resources as applicable via the LA.

Finally

- Safeguarding is everyone's responsibility
- Safeguarding should be considered as a safety net where there are concerns around patient neglect and risk of harm from abuse, due to patient vulnerability
- Safeguarding referrals are done via Datix, and the completed fields, with a copy of Datix forward to the appropriate LA (local authority)
- Patients/carers and significant others need to be given the right information at the right time, using jargon free terminology to make an informed decision, or in the patient's best interest, if the patient lacks capacity to make that decision
- There is a Patient Choice Agreement Form which should be frequently visited when patients decline intervention, when deemed to have mental capacity, specific to their health care need.