Department of Health & Social Care

Guidance

Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern

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Applies to England

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Foreword

I am delighted to publish this updated guidance with the aim of assisting practitioners and managers across health and care organisations to provide caring, speedy and appropriate responses to individuals at risk of developing pressure ulcers. Prevention of pressure ulcers is not only ideal but, in most cases, perfectly possible. Taking a proactive approach will reduce harm to individuals and secure efficiencies to the wider health and social care system.

Where pressure ulcers do occur, this guidance offers a clear process for the clinical management of the removal and reduction of harm to the individual, while considering if an adult safeguarding response under section 42 of the Care Act 2014 is necessary. The guidance demonstrates that the focus on removing harm to the individual will usually be secured by speedy clinical intervention.

Broader issues of overall quality of care, management of a service and training of staff will be of significant interest to commissioners and the regulator the Care Quality Commission, as well as Safeguarding Adult Boards (SABs) and Quality Surveillance Groups (QSGs). There should be clear processes in every locality for communicating concerns to the relevant bodies.

Pressure ulcers, largely preventable, cause distress to individuals and their families, as well as creating additional financial pressures for the NHS. While the treatment and response to pressure ulcers is a predominantly a clinical one, the prevention of them - our ultimate goal - is a shared responsibility. The reality is that many people at risk of pressure ulcers are receiving services that are commissioned, arranged and provided by non-clinical staff in the social care sector.

It is vital that any assessment, including risk assessments, address the likelihood of pressure ulcers developing and what action must be taken to prevent them. This will be as true for an individual living at home as those living in a regulated care setting. It is also vital that carers, whether family, friends or paid carers, receive training in the prevention and signs of developing pressure ulcers. Those responsible for carrying out assessments and arranging services need to be alert to this issue and have easy access to clinical advice to support care planning.

The content of this guidance reflects the 6 principles of adult safeguarding originally developed in 2011 and re-stated in the Care Act statutory guidance. I would urge everyone to familiarise themselves with those principles and ensure that their organisational procedures and practice are consistent with them.

This is a real opportunity to improve the lives of individuals and their families in a way that has the potential to significantly improve the quality of life for a great many people and I urge you to collaborate with partners at a local level to bring about positive change.

Lyn Romeo
Chief Social Worker for Adults

Introduction

This protocol provides a framework for health and care organisations to draw on when developing guidance for staff in all sectors and agencies that may see a pressure ulcer. If the staff member is concerned that the pressure ulcer may have arisen as a result of poor practice, neglect or abuse, or an act of omission, local guidance should be clear about what steps they need to take and whether the local authority safeguarding duties are triggered.

From a governance perspective, each organisation that uses this protocol will be responsible for ensuring that local guidance reflects that the protocol is used appropriately and that its use is monitored. SABs and QSGs will want to be reassured that this is the case.

This protocol should be applied to pressure ulcers reported by anyone including care providers, clinicians, anyone undertaking safeguarding enquiries, unpaid carers, relatives and individuals themselves, as any tissue damage resulting from pressure should be considered.

This protocol has been developed and agreed in the broader context of the implementation of the Care Act 2014 (https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted) and the drive towards greater integration between the health and social care systems. The core principle underpinning the Care Act is promoting individuals' wellbeing.

The imperative for this protocol derived from the increasing concern across the sector about the prevalence of pressure ulcers in all settings, and a lack of consensus about how investigating pressure ulcers should interface, or not, with local authority safeguarding duties as set out in the Care Act 2014 and the accompanying statutory guidance.

Practice in some places does not promote individuals' wellbeing and threatens to overwhelm the local authority adult safeguarding system.

This guidance updates the previous national standard protocol advising and supporting organisations in regard to pressure ulcers and the decision-making process as to whether a safeguarding concern should be raised with the local authority in order for them to decide if a section 42 safeguarding enquiry is required.

Those at risk of pressure ulcers are cared for in many different settings across health and social care, including their own home. Terminology used in these settings may vary - the terms patient, resident, service user and clients are all

often used. For the purpose of this guidance the term individual or person will be used throughout.

A helpful beginning point is the principle of wellbeing. As stated in the Care and Support statutory guidance (https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance), wellbeing is a broad concept and it's described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society

This principle requires all agencies to work together to achieve the best outcomes for the individual. The Care Act 2014 clearly lays out the duties of relevant partners to cooperate, including (but not only) local authorities and NHS bodies. This requires a shift of approach from one dominated by processes and tick boxes to a person-centred model that begins with the person at the centre of the concerns and fully involves them or their representative as appropriate. The response to the presence of pressure ulcers should involve the individual and their family, explaining the concerns and seeking their views.

Aim

The aim of this protocol is to provide a national framework, identifying pressure ulcers as primarily an issue for clinical investigation rather than a safeguarding enquiry led by the local authority. Indicators to help decide when a pressure ulcer case may additionally need a safeguarding enquiry are included.

While the operational responsibility for investigating pressure ulcers is largely health led, the local SABs have a strategic interest in the prevalence of pressure ulcers across the sectors as one indicator of quality of care. It is important that both the SABs and QSGs have access to comprehensive data on a regular basis. Where a pressure ulcer is one of a number of safeguarding concerns in relation to an individual or setting then there should be a multi-agency approach coordinated by the local authority, with health taking the lead for the clinical investigation.

Consideration of safeguarding

The Care Act 2014 says that the safeguarding duties (under section 42) apply where a local authority has reasonable cause to suspect that an adult in its area:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect

It is the responsibility of the designated safeguarding lead in each setting to appropriately triage any safeguarding concerns and ensure that referrals to the local authority for consideration of a section 42 (2) enquiry are appropriate.

The National Wound Care Strategy Programme (NWCSP) gives further information in the NWCSP Pressure Ulcer Recommendations (https://www.nationalwoundcarestrategy.net/pressure-ulcer/) document (October 2023).

Scope

The Care Act 2014 states clearly that concerns about the quality of a service provided are not automatically safeguarding concerns under section 42 of the act.

Safeguarding is about protecting an individual's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risk and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted - including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

Safeguarding adults is used to describe all work to help adults with care and support needs stay safe from abuse and neglect.

An adult at risk may therefore be a person who:

- is old and frail due to ill health, physical disability or cognitive impairment
- has a learning disability
- has a physical disability and/or a sensory impairment
- has mental health needs
- has a long-term illness or condition

- misuses substances or alcohol
- is a carer, such as a family member or friend who provides personal assistance and care to adults and is subject to abuse
- is unable to demonstrate the capacity to make a decision and is need of care and support

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.

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.

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.

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 existing local reporting systems. These arrangements must be clearly set out in local guidance for staff.

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.

Safeguarding concern assessment guidance

Where concerns are raised regarding skin damage as a result of pressure there is a need to raise it as a safeguarding concern within the organisation. In a minority of cases it may warrant raising a safeguarding concern with the local authority.

A history of the development of the skin damage should first be obtained by a clinician, usually a nurse. If the person's care has recently been transferred, this may require contact being made with former care providers for information, to seek clarification about the cause and timing of the skin damage. This is the responsibility of the organisation raising the concern.

Where there is concern that pressure ulceration has occurred, the practitioner should, in discussion with the individual and family, refer the individual to the appropriate local healthcare services, unless they are already in receipt of such services, even where they are in receipt of social care services.

If a concern is raised that a person has severe damage, you should:

- complete the adult safeguarding decision guide (see below)
- raise an incident immediately as per organisation policy

Note: severe damage is multiple pressure ulcers of category (or grade) 2, or a single case of category (or grade) 3 or 4 (to include unstageable and suspected deep tissue injury).

Adult safeguarding decision guide

The decision guide (appendix 1) 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.

Where the individual has been transferred into the care of the organisation it may not be possible to complete the decision guide. Contact should be made with the transferring organisation to ascertain if the decision guide has been completed or any other action taken.

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, 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 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 multi-agency meeting or virtual (telephone) meeting needs to be convened to agree findings, decide on safeguarding outcome and any actions.

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.

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) 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.

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), 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.

How to complete the safeguarding decision guide

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

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.

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.

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?

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.

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?

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?

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?

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?

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

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