NHS England

South Yorkshire & Bassetlaw Pressure Ulcer Good Practice Protocol for Safeguarding

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Contents

1 Introduction and Aim of the Protocol

This protocol provides guidance for staff in all service sectors in the South Yorkshire & Bassetlaw area who are concerned that a pressure ulcer (or other forms of skin damage) may have arisen as a result of poor practice, neglect, acts of omission or deliberate harm and therefore have to decide whether to make a safeguarding alert in line with the local multi agency Safeguarding Policy and Procedures. Promoting transparency within a multi-agency partnership approach to safeguard and protect vulnerable people from harm.

(The Care Act 2014)

This protocol should be used to decide whether to make a safeguarding alert and if applicable, report as a serious incident requiring investigation in respect of pressure ulcer care.

1.1 Pressure Ulcer Definition

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply. Typically they occur in a person confined to bed or a chair by an illness, and as a result they are sometimes referred to as 'bedsores' or 'pressure sores'

'Nice Clinical Guidance April 2014'

See Appendix 2, Pressure Ulcer Grading Tool

1.2 Safeguarding Responsibilities

Involving the person at risk (or carer/parent) in their own safeguarding is key to obtaining the best outcomes for the person, so that where possible they can decide what they want to do to feel safer, and consider how they can best protect themselves from abuse in the future.

1.3 Patient

Throughout this document the common terminology used is for a 'patient'. This also refers to a carer or parent where they are involved or requested to be involved in the care, and a resident of a care or nursing home.

1.4 Definition of an Adult at Risk of Abuse by a Third Party

The Care Act 2014 defines adult safeguarding as a means of protecting a person's right to live in safety, free from abuse and neglect. The Care Act requires that each authority must make enquiries or ensure others do so, if it believes an adult is at risk

of abuse or neglect. An enquiry should establish whether action needs to be taken to prevent abuse or neglect and if so by whom.

These duties apply in relation to any person who is aged 18 or over and at risk of abuse or neglect because of their needs for care and support.

1.5 Definitions of Safeguarding Children

The term 'safeguarding' and promoting the welfare of children is defined in Working Together 2013 as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

Some children will need protecting; child protection is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer significant harm as a result of maltreatment or neglect.

(Article 1, Convention on the Rights of the Child, 1989)

2 Safeguarding Principles

2.1 Safeguarding Adults Principles

Safeguarding adult processes are shaped by six leading principles to support how we safeguard patients:

Principle 1 – Empowerment – presumption of person lead decisions and consent

Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent, such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision they will still be included in the decision to the extent that they are able. Decisions made must respect the person's age, culture, beliefs, lifestyle and their background.

Principle 2 – Protection – support and representation for those in greatest need.

There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

Principle 3 – Prevention – avoiding harm or abuse is a primary goal

Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within health and care services by all staff groups.

Principle 4 – Proportionality – and least intrusive response appropriate to the risk presented.

Response to harm and abuse should reflect the nature of, and seriousness of the concern. Responses must be the least restrictive to the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

Principle 5 – Partnerships

The need to communicate and make links with staff from other organisations within the community is crucial

Principle 6 – Accountability – and transparency in delivering safeguarding

Services are accountable to patients, public and to their governing bodies. Working in partnerships also entails being open and transparent with partner agencies about how safeguarding responsibilities are being met.

'Adult Safeguarding: updated statement of government policy DH 2013'

2.2 Safeguarding Children Core Competencies

The core competencies for safeguarding children for all staff working in health services in any role (level 1) are about individuals knowing what to look for which may indicate possible harm, and knowing who to contact and seek advice from if they have concerns. It comprises of:

- Recognising potential indicators of child maltreatment – physical abuse including fabricated and induced illness, emotional abuse, sexual abuse and neglect including child trafficking
- Female Genital Mutilation (FGM)
- Understanding the potential impact of a parent/carers physical and mental health on wellbeing and development of a child or young person, including the impact of domestic violence
- The risks associated with the internet and online social networking, and understanding the importance of children's rights in the safeguarding/child protection context, and the basic knowledge of the relevant legislation

  (Children Acts 1989, 2004 and Sexual Offenses Act 2003)
- Taking appropriate action if they have concerns, including appropriately reporting concerns safely and seeking advice

3 Categories of Abuse

3.1 Safeguarding Adults Categories of Abuse

All categories of abuse must be carried out by another person or persons (a third party) and abuse may be intentional or unintentional.

- *Physical* - Assault, rough handling, unreasonable physical restraint
- *Psychological/emotional* - Bullying, intimidation, verbal attack or other behaviour that affects the wellbeing of an individual
- *Sexual and sexual exploitation* - Any non-consenting sexual act or behaviour
- *Financial* – theft, fraud, misappropriating funds i.e. when using a person's money or property for self-gain or gratification
- *Neglect* – a person's wellbeing is impaired and care needs not met
- *Discrimination* – Psychological abuse that is racist, sexist or linked to the persons sexuality, disability or age
- *Institutional* – Institutional abuse is the mistreatment, abuse or neglect of a vulnerable adult by a regime or individual. It can take place within settings and services that vulnerable adults live in or use, and it violates the persons dignity, resulting in a lack of respect for their human rights

3.2 Safeguarding Children Categories of Abuse

Categories and indicators of abuse in children (HM, 2013) are:

- *Physical abuse*
    - Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child or young person
    - Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child
- *Neglect* – the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development
- *Emotional abuse* - the persistent emotional maltreatment of a child such as to cause severe and persistent effects on the child's emotional development
- *Sexual abuse* – sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening
- *Peer abuse* – peer abuse can be defined as one who brings mistreatment, insult or deception in excessive amounts to another individual of the same peer group. This is done physically, mental emotionally or sexually.

This is only a brief overview. For more details on any of these please follow the link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

4 Pressure Ulcer Classifications

It is widely accepted that the majority of pressure ulcers are, for the most part, avoidable. However, there are circumstances that need to be considered when determining the classification of pressure ulcers and if a safeguarding alert would need to be made.

Avoidable Pressure Ulcer means that the person receiving the care developed a pressure ulcer and the provider of care did not do one of the following:

- Evaluate the persons clinical condition and pressure ulcer risk factors
- Plan and implement interventions that are consistent with the persons needs and goals, and recognise standards of practice
- If the patient has refused care or the carer has refused to deliver care and reasons have not been explored and choices have not been offered
- Monitor and evaluate the impact of the interventions, or revise the interventions as appropriate

Unavoidable Pressure Ulcer means that the individual receiving care developed a pressure ulcer even though the provider of care had:

- Evaluated a person's clinical condition and pressure ulcer risk factors
- Planned and implemented interventions that are consistent with the persons needs and goals, and recognised standards of practice
- Monitored and evaluated the impact of the interventions, or revised the interventions as appropriate
- The individual patient or carer chose not to adhere to the prevention strategies even though they had been educated and fully informed of the consequences of their choices.

The following list identifies circumstances when pressure ulcers are more likely to be unavoidable

Physical and social factors which may lead to unavoidable pressure ulceration:

- Haemodynamic or spinal instability may preclude turning or repositioning
- Patients may choose not to be repositioned
- Patients receiving end of life care may not be able to tolerate repositioning as frequently as their skin may require
- The patient has not previously been seen by a healthcare professional
- The patient has mental capacity but chose not to engage with assessment or treatment even where initial assessment showed signs of pressure damage

- The patient is known to a healthcare professional but an acute/critical event occurs which affects mobility or the ability to reposition. For example the patient being undiscovered for a period following a fall or loss of consciousness

Achieving Consensus in Pressure Ulcer Reporting (Adapted from TVS 2012)

5 Pressure Ulcer Prevention

Preventing pressure ulcers should be a key priority for all agencies and may or may not be an indicator of abuse. They do however, have a significantly adverse effect upon a person's quality of life and where possible should be prevented.

- All care, support and explanation for patients who are at risk of developing pressure ulcers, or who have pressure ulcers, has to be done within the principles of the Mental Capacity Act
- The engagement of carers, paid and unpaid, and legal representatives (holding Lasting Power of Attorney) for health and welfare and relatives should be evident
- Patients receive an initial and ongoing risk assessment within a maximum of 6 hours of the first point of contact within each care environment
- Those assessed at risk should be cared for as guidance suggests dependent upon the degree of risk
- This should include a care plan that records the frequency of pressure area care required, skin care regime and the type of pressure relieving equipment required
- The optimum environment should be created to maintain skin integrity or where compromised, the ideal wound healing interventions. This will include satisfactory maintenance, referral, management of nutrition and hydration, hygiene, continence care and maintaining mobility
- Good communication is essential, which would include accurately recorded assessments, care/treatment plan, transfer/discharge forms and includes open and transparent and appropriate information sharing between agencies

5.1 Safeguarding Considerations

- Any pressure ulcer and/or moisture lesion may be an indicator of neglect/abuse, therefore all should be appropriately assessed and screened to identify any possible safeguarding concerns
- Not all grade 3 and 4 pressure ulcers are indicative of neglect/abuse.
- Patients must be involved and empowered to engage with all stages of the safeguarding process and their preference must be recorded

- Once a safeguarding concern is identified, a safeguarding alert must be raised within the guidelines of the local policy and procedures timescales to safeguard adults from abuse
- Keep up to date with best practice and evidence through learning the lessons from the investigation process

Following a Root Cause Analysis assessment, if you have indicated that in your clinical opinion the pressure ulceration was avoidable, then a safeguarding adult's alert should be made. You do not need to prove that the pressure ulcer is a result of abuse or neglect before raising a safeguarding alert. It is important to remember that one type of abuse does not always happen in isolation. Therefore when considering pressure ulcer damage you should also consider whether there is evidence of other forms of abuse.

Rationale for making a safeguarding alert or **not** making a safeguarding alert should always be recorded on the assessment form. When considering a safeguarding children referral note, the terminology is often different from 'alert'.

6 Responding to Concerns

6.1 Duty of Candour

There is a duty of candour in relation to pressure ulcer development and investigation. This involves the volunteering of all relevant information to a person who may or may not have been harmed. This should be prompt, providing information and explanations.

Care organisations have a duty to report safeguarding concerns in an open and transparent way. This applies when patients develop a pressure ulcer and it is indicated that the wound was avoidable.

The NMC Code of Conduct is clear regarding our responsibilities to the people we care for and underpins our duty of care.

(NMC CoC 2014)

6.2 Root Cause Analysis Principles

Root Cause Analysis is a well-recognised way of reviewing incidents to learn lessons to prevent the same incident occurring again.

Root Cause Analysis is a method of investigation to identify how, and in particular, why, patient safety incidents happen and to capture and share learning. It involves analysis to identify areas for change and to develop recommendations.

Root Cause Analysis involves an investigations process. Often identified individuals come together to undertake this. The process involves:

- Gathering and mapping information
- Identifying care and service delivery problems
- Analysis to identify contributory factors and root causes
- Generating solutions

Recommendations and actions are usually identified and an investigation report produced and learning shared.

(National Patient Safety Agency)

6.3 Your Role as an 'Alerter' in the Safeguarding Process

The 'Alerter' raises a safeguarding concern within their own agency following that agency's own policies and procedures. This concern may result from something that an individual has seen, been told, observed or heard.

See Appendix 1 – Pressure Ulcer/Safeguarding Flow Chart

Contact the police where a crime has been committed, including wilful neglect, a person is in immediate danger or where there are any other safeguarding risks.

6.4 Reporting and Information Sharing

Information disclosed should be:

- Clear regarding the nature of the problem and the purpose of sharing it
- Based on fact, not assumption
- Restricted to those with a legitimate need to know
- Relevant to a specific incident
- Strictly limited to the needs of the situation at that time but should include relevant patient history
- Recorded in writing, with reasons stated

6.5 Sharing Information When a Patient Lacks Mental Capacity

Can the patient give consent to disclosure of information?

There is a responsibility to explore approaches to help the patient understand. In some instances the individual will not have the capacity to consent to the disclosure of personal information relating to a specific incident.

In those instances information can be shared if it is deemed to be in the patient's best interests.

7 Summary

This guidance has been developed to support professional decision making when patients develop a pressure ulcer and there is a need to assess, investigate and determine if this needs to be reported as a safeguarding incident.

8 Contributor Organisations

Barnsley Hospitals NHS Foundation Trust
Bassetlaw Clinical Commissioning Group
Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Doncaster Clinical Commissioning Group
Leeds Teaching Hospitals NHS Trust
NHS England - London
NHS England – South Yorkshire & Bassetlaw
Rotherham Doncaster & South Humber NHS Foundation Trust
Sheffield Clinical Commissioning Group
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
The Rotherham NHS Foundation Trust
University of Leeds

9 References

Department of Health (2010) Clinical Governance and Adult Safeguarding an Integrated Process

EPUAP (2009) http://www.epuap.org/wp-content/uploads/2010/10/NPUAP-EPUAP-PPPIA-Quick-Reference-Guide-2014-DIGITAL.pdf

Newcastle Safeguarding Adults Board (July 2010) Safeguarding Adults and Skin Damage Protocol

NICE (2005) The Management of Pressure Ulcers in Primary and Secondary Care

NICE (April 2014) Pressure Ulcers: Prevention and management of pressure ulcers

SCIE (2012) Commissioning Care Home Common Safeguarding Challenges http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/

North Yorkshire Pressure Ulcer Protocol for Adult Safeguarding December 2013

Building Partnerships, Staying Safe: the healthcare contribution for healthcare workers can be found on https://www.gov.uk/government/publications/the-health-sector-contribution-to-hm-government-s-prevent-strategy-guidance-for-healthcare-workers

Clinical Governance and Adult Safeguarding: An integrated process (DH 2010). http://www.nmc-uk.org/Documents/Safeguarding/England/1/Clinical%20governance%20and%20adult%20safeguarding.pdf

Pressure Ulcer Guidelines**:** http://www.epuap.org/ http://www.npuap.org/ http://guidance.nice.org.uk/CG29

HM Government (2013) Working Together To Safeguard Children

Royal College of Paediatrics and Child Health **(***2014) Safeguarding Children and Young people: roles and competences for health care staff*

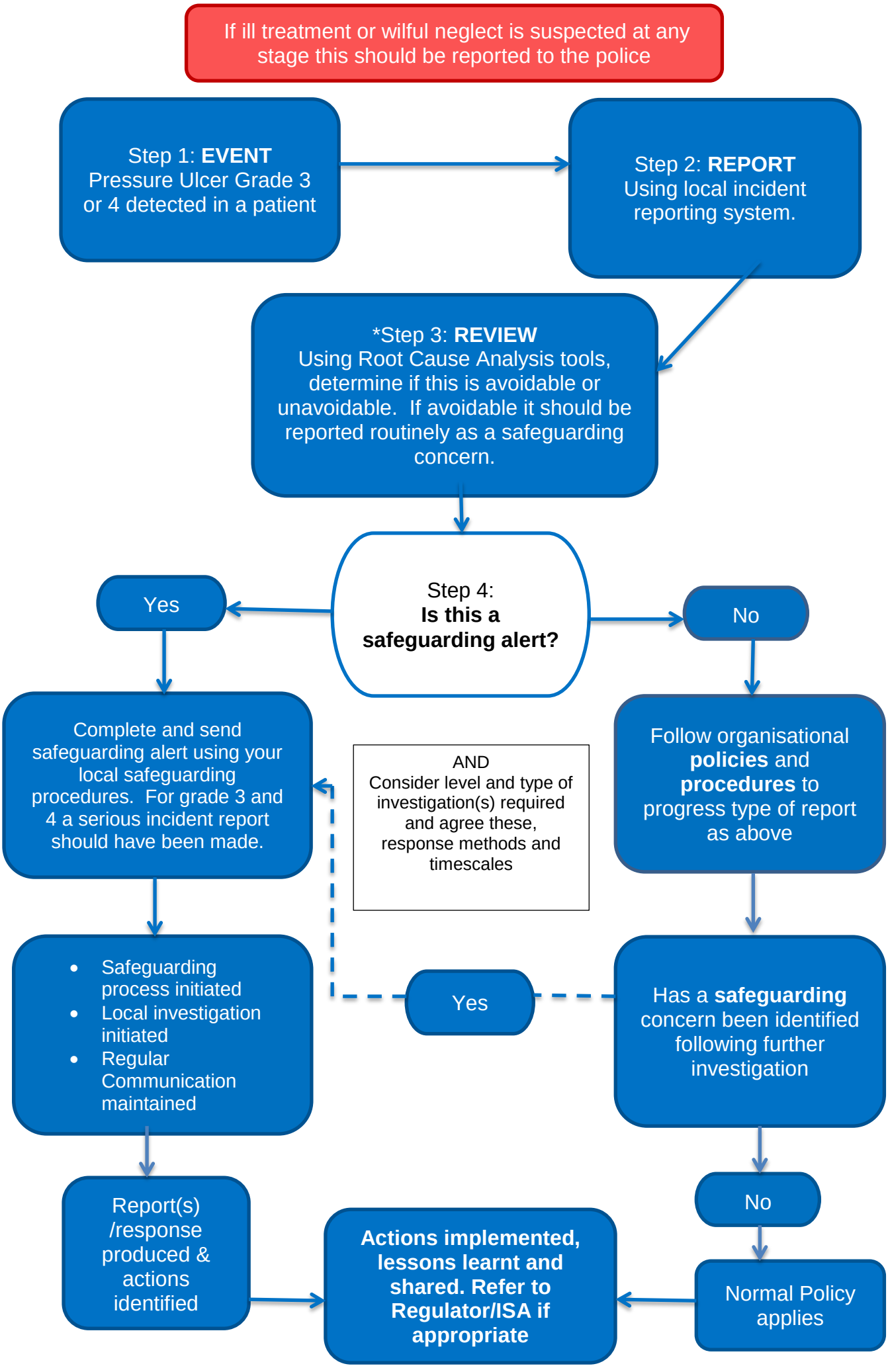
Article 1, Convention on the Rights of the Child, 1989

NMC Code of Conduct http://www.nmc-uk.org/Documents/Consultations/NMC%20Consultation%20-%20code%20of%20conduct%20-%20%20Phase%202%20draft%20code.pdf

The Care Act 2014

New Offences of Ill-treatment or Wilful Neglect – June 2014

Appendix 1 – Pressure Ulcer / Safeguarding Alert Flow Chart



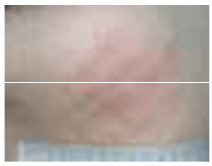
Appendix 2 – Pressure Ulcer Grading

Pressure Ulcer Grading

To support your practice

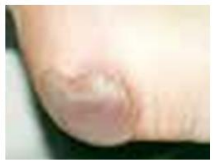
Pressure Ulcer Grading (adapted from EPUAP/NPUAP 2009)

Superficial



EPUAP- Category/Grade I

- Non-blanchable erythema of intact skin: persistent redness in light pigmented skin.
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple.
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).



EPUAP System Category/Grade 2

- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising*
- Check for moisture lesion.

*Bruising appearance and blood filled blister would indicate deep tissue injury.

Deep

EPUAP- Category/Grade 3

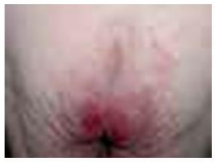
- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep grade 3 pressure ulcers.
- Bone/tendon is not visible or directly palpable.

Plus: Unclassified Pu how Grade 3

- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either grade 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as 'the body natural (biological) cover' and should not be removed.
- Should be documented as grade 3 until proven otherwise.

EPUAP–Category/Grade 4

- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow.
- Grade 4 ulcers can extend into the muscle and/or supporting structures (e.g. fascia, Tendon or joint capsule).



Moisture Lesions

- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.