



Croydon Multi-Agency
SAFEGUARDING
ADULTS BOARD

Safeguarding Adults and Pressure Ulcer Protocol

DECIDING WHETHER TO REFER TO SAFEGUARDING ADULTS

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1. Introduction

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) and the drive towards greater integration between the health and social care systems. The core principle underpinning the Care Act (2014) is promoting individuals' well-being. It is important that all pressure ulcers, except in people who were unknown to NHS funded services, are recognised as patient safety incidents and reported accordingly. All patient safety incidents should be reported to the National Reporting and Learning System (NRLS) for the purposes of national learning (NHSE, 2018).

1.1 Statutory guidance outlines the categories of abuse including neglect as well as the 4 steps safeguarding process. The Local Authority is the lead agency under section 42 of the Care Act (2014)

1.2 Each organisation (Local Authority, Clinical Commissioning Groups, Health and Social care providers) will be responsible for the implementation of the Protocol in line with organisational policies to provide the Safeguarding Adult Board (SAB) and the Quality Surveillance Groups (QSGs) with assurance that it is:

- Ensuring that the Protocol is implemented
- Monitoring the compliance with the Protocol
- Time of reviewing of the Protocol will be discussed by the CSAB

2. The Aim and Purpose of the Protocol

This is a borough wide protocol across Croydon which provides guidance to staff in all sectors across the health and social care economy. Therefore this document applies to those involved in the care of adults who are responsible for the prevention and reporting of pressure ulcers (or other forms of skin damage). The skin damage may have arisen, as a result of the person's health status, poor practice or neglect/abuse.

Therefore this protocol aims to help the professionals involved in their decision to raise a safeguarding with the Local Authority or not and:

- Provide better understanding of the processes
- Assist staff to understand when to report a Serious Incident (SI) and/ or

the multi-agency safeguarding process

- Provide a pathway to show how the processes should be integrated
- Clarity around roles and responsibilities
- Reduce duplication of the investigative process
- Encourage positive partnership working
- Assist the decision making process
- Ensure lessons learnt from incidents and safeguarding concerns are identified and shared appropriately

3.1 This is a multi-agency protocol including a decision guide (Skin Damage Tool) 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.

3.2 The protocol 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 Pan London policy and procedures. A flow diagram outlining the key elements of the protocol can be found for each setting.

4) Accompanying decision making flowcharts for the Protocol - specific to each setting as follows:

- Health in Patient Care (Hospital)
- Community Health Care (General Practitioner (GP), Tissue Viability Nurse (TVN), District Nurse (DN) & Health Visitor (HV))
- Residential Domiciliary & Care (including supported living and shared lives)
- Nursing Home Care

Linking safeguarding and pressure ulcers

- 4.1 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, which, in the context of pressure ulcers, may present as grade 3 or 4 or multiple grade 2 wounds.
- 4.2 Skin damage has a number of causes, some relating to the individual persons health status, 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 (See Appendix 2 “Risk Assessment Guidance”, consider this before raising a safeguarding alert & the Skin Damage Tool must be completed first). All cases of actual or suspected neglect should be referred through the safeguarding procedures.
- 4.3 Any category/grade 1 and above pressure ulcer must be reported (accordingly within your organisation) as a clinical incident /Datix according to local serious incident reporting policy. It should be noted that all grade 3 and 4 pressure ulcers should be managed in line with the Serious Incident (SI) Framework and a concise Root Cause Analysis (RCA) should be completed.
- 4.4 Cases of single grade 1 and 2 pressure ulcers must be considered as requiring early intervention to prevent further deterioration. To maintain good wound care follow your local policies and procedures relating to the prevention of pressure ulcers. If there are concerns regarding poor practice, an appropriate escalation must be considered, i.e. raising a clinical incident/ Datix, Serious Incident.
- 4.5 The person should be referred to Croydon Council’s Safeguarding Team through local arrangements if there is evidence of a score of 15 or above the Skin Damage Tool (Appendix 2). This is likely to include one or more of the below:-
 - Significant skin damage (i.e. Category/ grade 3 or 4, unstageable ulceration or multiple grade2). National Pressure Ulcer Advisory Panel (NUAP) classification System⁵ (“Prevention and Treatment of Pressure Ulcers”: 2009). View as accepted classification system
 - There are reasonable grounds to suspect that it was preventable or

- Inadequate measures taken to prevent development of pressure ulcer, or⁶
- Inadequate evidence to demonstrate the above

4.6 This protocol should apply to pressure ulcers identified within the four settings (See the flow charts for each setting).

- Health in Patient Care (Hospital)
- Community Health Care (General Practitioner (GP), Tissue Viability Nurse (TVN), District Nurse (DN) & Health Visitor (HV))
- Residential Domiciliary & Care (including supported living and shared lives)
- Nursing Home Care

It is the responsibility of the professionals in each setting to follow the protocol when pressure ulcers are reported by relatives or other Health and Social Care professionals.

4.7 There may be incidents of pressure ulcers developing in service users living in the community not engaged with any services. Under such circumstances a referral for a health & social care assessment needs to be made. In such instances there may be indicators of self-neglect which should be referred to the local authority as a safeguarding concern.

4.8 It is accepted that skin damage identified in one setting may have been precipitated by care provided in a previous setting. Therefore it is important to gather information from the relevant previous care provider(s). It is the responsibility of the previous care provider to deliver full information to the current care provider, to enable them to complete the Skin Damage Tool (Appendix 2).

4.9 Staff should also refer to:
Their own organisation's policies and procedures on pressure ulcers as well as other relevant local, and national guidelines (Department of Health and Social Care 2018), protocols and policies e.g. NICE Guidance Incident Reporting Policies.

⁵National Pressure Ulcer Advisory Panel (NPUAP) Classification system (category stage 1-4) ⁶
With reference to the NICE guideline 179 and local policies

5. How to use the guidance of the Skin Damage Tool

The assessment of the wound and completion of the decision guide must be completed by a qualified member of staff who is a practicing registered nurse (RN), with experience in wound management and ideally not directly involved in the provision of care to the patient. This does not have to be a Tissue Viability Nurse.

5.1 Assessment must involve a second member of staff. This could either be the line manager or any of the positions listed here:

- Matron
- Care Homes Support Team Specialist Nurse (CHSTSN)
- Tissue Viability Nurse (TVN)
- Continuing Health Care Nurse (CHCN)
- District Nurse (DN)
- Experienced HCA (second signature only) who had attended pressure ulcer training

They may or may not be directly involved in the patient's care. Their role is to contribute to the assessment process and verify that procedures have been carried out correctly. This outcome of the decision guide must be documented on the skin damage tool (Appendix 2). If further advice/support is needed with regards to making the decision to refer to the local authority, the adults safeguarding lead within the organisation should be contacted.

5.2 The skin damage tool should be completed 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.

5.3 Where the individual has been transferred from another organisation to another organisation it may not be possible to complete the skin damage tool. Contact should be made with the transferring organisation to ascertain if a safeguarding alert has been raised or the skin damage tool has been completed; if neither then the provider where the individual is now residing should request information from the previous provider who has an obligation ("duty of care") to comply immediately with giving the information.

5.4 If a patient/client transfers their place of care and has a pressure ulcer at the original setting, the Skin Damage Tool should accompany them in the transfer and be clearly communicated.

NOTE: If information is not shared the care provider seeking the information must escalate the matter to the management of the agency failing to provide the information. (e.g safeguarding lead of a hospital)

5.5 After completing the Skin Damage Tool and the score is 14 or below, then the matter may not be safeguarding and may not need to be referred as such.

Effective clinical care needs to continue as per wound management policy in the organisation but this tool has to be revisited if there are deterioration.

- 5.6 If the score is 15 or above then the case needs to be referred to the Croydon Council's Safeguarding Team. Any case referred to the safeguarding team must be accompanied by the Skin Damage Tool (SDT). The Skin Damage Tool (SDT) may be emailed securely as a separate document to Referral.team2@croydon.gov.uk.
- 5.7 Care homes, health providers and hospitals must inform the CQC. NHS providers may not directly inform the CQC but rather inform via datix and other quality measures to the commissioning teams who will then inform the CQC.
- 5.8 Health providers must also carry out a Root Cause Analysis (RCA) for all grade 3, grade 4 and multiple grade 2s. These may score 14 or below on the Skin Damage Tool (SDT) (thus not safeguarding) but will still need to be reported via datix and form part of the Serious Incident (SI) process.
- 5.9 The safeguarding duty team will receive the referral and decide the way forward for the safeguarding process according to the Care Act (2014) and Pan London Multi Agency Safeguarding Adults Policy and Procedures. If a safeguarding meeting is required, then referring professionals may be asked to attend. The process of making safeguarding enquiries will incorporate information from the SI investigations carried out by Croydon Health Care Providers, where appropriate

NOTE: If there are concerns around discharging a client to a care setting where the pressure ulcer may have developed, then hospital staff should consult with the hospital social work team before completing discharge planning.

APPENDIX 1

RISK ASSESSMENT GUIDANCE

This section is simply to provide practitioners with a set of guidance notes about how to assess skin damage risk to help prevent skin issues. It is not a part of the Skin Damage Tool.

HISTORY

- Include any factors associated with the individual's behaviour that should be taken into consideration e.g. spend prolonged time in chair

MEDICAL HISTORY

- Does the individual have a long term condition, which may impact on skin integrity; such as Rheumatoid Arthritis, Diabetes, COPD or steroid use
- Is the person receiving End of Life (EoL) care?
- Does the person have any mental health needs or cognitive impairment, which might impact on skin integrity? Example: dementia/ depression.
- Consider; is there a history of previous pressure ulcers, is there a history of limited mobility, is there a history of loss of sensation

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 individual have reasonably required the monitoring of their skin integrity (where no monitoring has taken place prior to skin damage occurring)?
- Did the individual refuse monitoring? If so, did the individual have the mental capacity to refuse such monitoring?
- Were any further measures taken to assist understanding e.g. patient information, leaflets given, escalation to line manager, clinical specialist, ward sister, 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 persons needs being met? E.g. history of self-neglect, lifestyle choices and patterns, substance misuse, unstable housing, faith,

mental ill health, learning disability

EXPERT ADVICE ON SKIN INTEGRITY

- Was appropriate assistance sought? Example: professional advice from a Community Nurse Clinical Lead or Tissue Viability Specialist Nurse, Vascular Surgeon or GP.
- 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? (E.G. Pressure Ulcer Proforma⁷, Waterlow Scoring).
- 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 individual has been assessed as lacking mental capacity⁸ 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 individual have continence needs? 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 individual person look emaciated (loss of weight) or dehydrated?

⁷ PUP (Pressure Ulcer Proforma) ⁸
Mental Capacity Act 2005

- Is there evidence of intake monitoring (food and fluids)?
- Has individual lost weight recently? If so, is person's weight being monitored?
- Is the individual receiving sedation? If so is the frequency and level of sedation appropriate?
- Is the individual in pain? If so has it been assessed? Is it being managed appropriately?
- Is the individual able to reposition themselves?

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 individual been on the floor for extended periods?

APPENDIX 2

SKIN DAMAGE TOOL
TO DECIDE WHETHER TO REFER TO CROYDON SAFEGUARDING
ADULTS

Details of individual with pressure ulcer(s)			
First name		Last name	
D.O.B		NHS Number	
Address		Borough of usual residence	Medical History (Past & Present):
Persons completing decision guide for safeguarding concern			
Department/ Base /Address		Organisation Name	
		Telephone Number	
Name of assessing nurse (PRINT)			
Job Title		Signature/date/time	
Name of second assessor (PRINT)			
Job Title		Signature/date/time	

Synopsis of concern regarding pressure ulceration and safeguarding

State site and condition/
Category/ grade
of all pressure
ulcer(s)

	Q	Risk Category	Level of	Score	Evidence
Skin Damage Tool Score	1	Has the patient's skin deteriorated to either grade 3/4/ unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/ visit	Yes e.g. record of blanching/ non blanching erythema /grade 2 progressing to grade 2 or more	5	E.g. evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
			No e.g. no previous skin integrity issues or no previous contact health or social care services	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	Change in condition contributing to skin damage	0	
			No change in condition that	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	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
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	0	
		Yes	15	
5 5	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	
6	Answer (a) if your patient has capacity to consent to every element of the care plan Answer (b) if your patient has been			
a	Was the patient compliant with the care plan having received information regarding the risks of non-compliance	Patient not	0	
		Patient compliant with	3	
		Patient compliant with care plan or not given	5	
b	Was appropriate care undertaken in the patient's best interests, following the best interest checklist in the Mental Capacity Act Code of Practice? (supported by	Documentation of care being undertaken in patient's best interests	0	

	documentation, e.g. capacity and best interest statements and record of care delivered)	No documentation of care being undertaken in	10	
	TOTAL SCORE			

If the score is 15 or over refer for Safeguarding by sending this form as your safeguarding referral to the relevant duty social worker.

When the protocol has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the patient's notes

Patient Name:

Patient NHS/ Hospital number (if known):.....

Summary/
rational for
decision re
safeguarding
referral

Safeguarding referral

Not for safeguarding referral

If the score is 15 or over refer for Safeguarding by sending this form as your safeguarding referral to the relevant duty social worker.

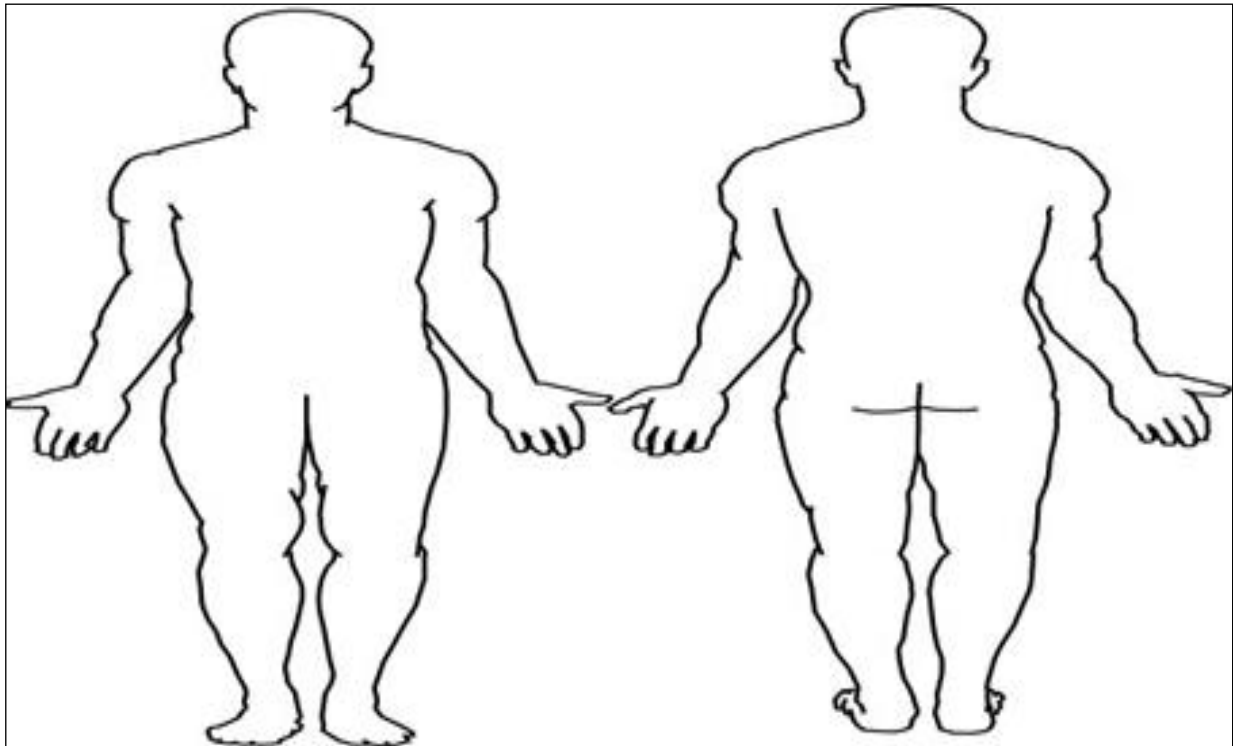
When the protocol has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the patient's notes (Attach Datix document and inform manager & safeguarding lead).

BODY MAP

Patient Name:

Patient NHS/ Hospital number (if known):

Body maps must be used to record skin damage and can be applied as evidence if necessary at a later date. If two workers observed the skin damage they should both sign the body map.



Name of assessing nurse (PRINT)			
Job Title		Signature	
Name of second assessor (PRINT)			
Job Title		Signature	

Guidance notes about the APPENDIX 2

1. Concern is raised that a person has severe pressure damage Category/grade 3, 4, unstageable, suspected deep tissue injury or multiple sites of category/grade 2 damage (EPUAP, 2014)
2. Complete adult safeguarding decision guide and raise an incident immediately as per organisation policy.

Score 15 or higher: Concern for safeguarding

IF YES:

Discuss with the person, family and/ or carers, that there are safeguarding concerns and explain reason for treating as a concern for a safeguarding enquiry has been raised.

1. Refer to local authority via local procedure, with completed safeguarding pressure ulcer decision guide documentation.
2. Follow local pressure ulcer reporting and investigating processes.
3. Record decision in person's records.

IF NO

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 emphasis the actions which will be taken.

1. Action any other recommendations identified and put preventative/ management measures in place.
2. Follow local pressure ulcer reporting and investigating processes.
3. Record decision in person's records.

****PLEASE SHARE AND DISPLAY THE RELEVANT FLOWCHART TO STAFF****

- Health in Patient Care (Hospital)
- Community Health Care (General Practitioner (GP), Tissue Viability Nurse (TVN), District Nurse (DN) & Health Visitor (HV))
- Residential Domiciliary & Care (including supported living and shared lives)
- Nursing Home Care

You can download copies of the protocol and flowcharts from www.croydonsab.co.uk

APPENDIX 3

TERMS AND DEFINITIONS

ADULT ABUSE

Is “a violation of an individual’s human and civil rights by any other person or persons” (DOH, 2000).

“ADULT S WITH CARE AND SUPPORT NEEDS: SEC 14.2 OF THE CARE ACT GUIDANCE

The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- 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

AIS NUMBER

Croydon Council’s Electronic systems used to record confidential client information. Each client is given a unique client number.

CRIME

An action prohibited by law or failure to act as required by law e.g. physical and sexual assault, theft, fraud, financial exploitation, discrimination.

INCIDENT

‘Is an unwanted, unplanned or unexpected event or accident that may or may not, result in physical or emotional injury, loss or damage or risk thereof. The incident may involve patients, clients, visitors, relatives, staff, formal or informal carers, occurring on Trust premises, independent contractors’ premises or in a patient’s home.

INCIDENT REPORTING FORM AND DATIX

A form of electronic system on which the details of the incident are recorded in health. The document is then countersigned by the line manager and sent to the risk

manager.

INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA):

Where a person lacks capacity a referral may be made for an IMCA when there are adult protection concerns. Their role includes: support & representation. They have the right to see health & social care records. Authorities must take account of the IMCA's comments/findings in the decision making process. IMCAs must be independent of decision makers; and must represent the person to promote their best interests.

MINOR TO MODERATE INCIDENT

'An incident where minor or moderate harm, loss or damage occurs but does not result in time off from work or disruptions of work/service'. An incident, that normally scores 1 to 12 on the Incident Grading Matrix.

NEAR MISS

'An event or omission that does not result in actual harm, loss or damage but might have produced unwanted or unexpected consequences'.

SAFEGUARDING ADULT REVIEW (SAR) (SECTION 14.133 OF THE CARE ACT GUIDANCE)

Safeguarding Adult Boards must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

SERIOUS INCIDENT (SI)

An accident or incident causing significant loss or damage, serious harm or injury, (e.g. all Grade 3 or 4 pressure ulcers), or unexpected death,; involving a patient, member of staff, visitor on Trust property, contractor or other person to whom the organisation owes a duty of care; which may or may not attract adverse media attention or where litigation is expected. An incident, that normally scores above 12 on the Incident Grading Matrix.

SIGNIFICANT SKIN DAMAGE:

'Significant skin damage' is indicated by multiple lesions of grade 2 or a grade 3 or greater wound as defined by the European Pressure Ulcer Advisory Panel (EPUAP) classification system of pressure ulcer grades.

TYPES OF ADULT ABUSE (SEE SECTION 14.17 OF THE CARE ACT)

GUIDANCE)

Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Domestic violence – including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence.

Sexual abuse – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

Discriminatory abuse – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

Organisational abuse – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, withholding of the necessities of life, such as medication, adequate nutrition and heating.

Self-neglect – this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.



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<http://www.croydonsab.co.uk/>