



## Bath & North East Somerset Local Safeguarding Adults Board

# Protocol for Determining Neglect in the Development of a Pressure Ulcer

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**National and Regional Context: This protocol is supported by the following legislation and guidance:**

- The Care Act (2014)
- The Health Act (2009)
- The Mental Capacity Act (2005)
- The Deprivation of Liberty Safeguards (2007)
- The Health Act (2009)
- Duty of Candour (2014)
- Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Essential Standards of Quality and Safety 2010 (Care Quality Commission)
- Regional and national guidance for Social Services
- Making Safeguarding Personal (LGA/ADASS 2014)
- Clinical Guidelines for the Prevention and Treatment of Pressure Ulcers (The National Institute for Health and Clinical Excellence 2014)
- The European Pressure Ulcer Advisory Panel (EPUAP) and The National Pressure Ulcer Advisory Panel (NPUAP) (2014)
- Clinical Governance and Adult Safeguarding: An Integrated Process (DOH 2010)
- Serious Incident Framework – Supporting Learning to Prevent Recurrence (NHS England 2015)
- Essential Standards of Quality and Safety – Section 20 Regulations of the Health & Social Care Act (DOH 2011) – Specifically Outcome 7
- Safeguarding Adults: The Role of Health Services (DOH 2011)
- Commission on Dignity in Care for Older People – Delivering Dignity (2012)
- Nursing and Midwifery Council – Standards and Code of Practice (2014)
- NHSI Pressure Ulcers: revised definition and measurement (June, 2018)

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## PART 1: CONTEXT AND LEGAL FRAMEWORK

### 1. Introduction

Pressure ulcers are costly in terms of both human suffering and the use of resources (EPUAP 2014). The one defining feature is that in the majority of cases pressure ulcers are preventable if simple measures are followed and so; not to prevent the preventable could constitute neglect (Hofman 2006).

It is estimated that just under half a million people in the UK will develop at least one pressure ulcer in any given year, usually affecting people with an underlying health condition. Within these statistics, around 1:20 people who are admitted to hospital with an acute illness will develop a pressure ulcer (NHS Choices Oct 2010).

The overall purpose of this protocol is to protect adults at risk by providing a framework to guide health and social care agencies on whether safeguarding procedures need to be instigated when concerns have been raised that a pressure ulcer may have developed as a result of neglect. Whilst Category 3 and 4 and multiple Category 2 pressure ulcers will be routinely scoped to determine whether safeguarding procedures are indicated, any category of ulcer (EPUAP 2014) should be considered as possible neglect (see Appendix 1 for category classification). Classification now includes Deep tissue Injury (DTI), and organisations should follow the current system recommended in the international guidelines, NPUAP/EPUAP/PPPIA (2014) incorporating unstageable ulcers (Pressure Ulcers: revised definition and measurement (June, 2018).

This protocol will enable staff to identify if it is likely the pressure ulcer was caused as a result of neglect and will also provide a focus on thresholds for referral through the Safeguarding Adults process. **It is important that this protocol dovetails into and is embedded within each organisation's own pressure ulcer prevention and management policies and guidance.**

### 2. Scope

This protocol applies to all Health and Social Care staff working in Bath & North East Somerset with adults who develop a pressure ulcer or are at risk of developing a pressure ulcer. This guidance should not replace the need to read and refer to the following documents:

- [Care Act 2014: Care and Support Statutory Guidance](#)
- [The Mental Capacity Act 2005](#)) and [The Mental Capacity Act Code of Practice](#))
- [Joint Regional Safeguarding Adults Multi-Agency Policy](#) (June 2019)
- [B&NES LSAB Multi-Agency Safeguarding Adults Procedures](#) (September 2018)
- [B&NES LSAB MA Safeguarding Adults Procedures Flowchart - One Page](#) (September 2018)

- [Multi Agency Safeguarding Adults Consent Policy \(June 2018\)](#)
- [Multi Agency Information Sharing Protocol \(June 2018\)](#)
- [Self Neglect Policy and Guidance \(March 2019\)](#)
- [Quick Guide to the Self Neglect Policy and Guidance \(March 2019\)](#)

All up to date LSAB Policies are available on: <https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board/4-isab-multi-agency-policy-and-procedures>

## **2.1 Partnership organisations should also have the following policies and procedures in place to support practice**

- Consent Policy
- Information Sharing protocols
- Incident reporting and Serious Incident Reporting Policy and Procedures
- Whistle Blowing Policy
- Dignity in Care Policy
- Withholding Care Policy and guidance on Non-Concordance with Care and Treatment
- Pressure Ulcer Prevention and Management Guidelines
- Safeguarding Adults from Abuse Policy and Procedures
- Assessment of Mental Capacity and Determining Best Interest Guidance
- Duty of Candour

## **3. What is a pressure ulcer?**

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful (Pressure Ulcers: revised definition and measurement, June 2018).

Pressure ulcers can occur in any individual but are more likely in high risk groups, such as the elderly, people who are obese, malnourished or who have continence problems as well as people with certain skin types and those with particular underlying conditions.

Ulceration occurs when the skin and underlying tissues are compressed for a period of time, between the bone and the surface, on which the individual is sitting or lying. Blood cannot circulate causing a lack of oxygen and nutrients to the tissue cells. Furthermore, the lymphatic system cannot function properly and remove waste products.

If the pressure continues, the cells die and the area of dead tissue that results is called pressure damage. The amount of time that this takes will vary, but may develop in as little as one hour in individuals at greatest risk.

A pressure ulcer that has developed due to the presence of a medical device should be referred to as a 'medical device related pressure ulcer' this is the case for pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes (Pressure Ulcers: revised definition and measurement, June 2018), in addition, moisture-associated skin damage (MASD) should be counted and reported.

## 4. The Legal Framework

### 4.1 The Care Act (2014)

[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 that others do so (Section 42), if it believes that an adult who is aged 18 or over -

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect him or herself against the abuse or neglect or risk of it

The decision to carry out a section 42 Enquiry under the Care Act does not depend on the person's eligibility to receive care and support, but should be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect

The Act (section 1) provides particular focus on well-being in relation to an individual, and requires that organizations promote this in their safeguarding arrangements. The Act defines wellbeing for individuals as:

- 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 their day-to-day (including over care and support provided and the way they are provided)
- Participation in work, education or recreation
- Social and economic wellbeing
- Domestic, family and personal
- Suitability of the individual's living accommodation
- The individual's contribution to society.

The principles of promoting a person's wellbeing are also supported by 'Making Safeguarding Personal' (2014), which seeks to ensure that where possible, the individual is involved in their own safeguarding and that it is 'person-led', 'out-come' focused but not process driven.

### 4.2 Advocacy

The involvement of an independent advocate as determined under [The Care Act \(2014\) Statutory Guidance](#) – section 7:93 or an Independent Mental Capacity Advocate (IMCA) - [The Mental Capacity Act Code of Practice](#) (chapter 10) should be considered as appropriate.

### **4.3 Mental Capacity Act (2005)**

The MCA has been in force since 2007 and applies to England and Wales. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. All professionals are therefore required to work in accordance with the MCA and its Code of Practice ([The Mental Capacity Act Code of Practice](#)) upholding at all times the Act's Five Key Principles (**Appendix 1**)

When safeguarding concerns arise, the mental capacity of the person involved should be clarified at the outset. This is particularly important where the individual appears to be non-concordant with recommended care and/or treatment. If a person has been assessed as lacking capacity then any action taken, or any decision made for or on behalf of that person, must be made in his or her best interests.

The Mental Capacity Act (Section 44) introduced a criminal offence of ill treatment or neglect of a person who lacks capacity. If a criminal offence is suspected, it is the role of the Police to investigate. The case should also be referred into Adult Safeguarding. Within the Safeguarding Adults Policy and joint working arrangements, partnership agencies may be required to work jointly with the Police during the investigation and/or assist in information gathering.

### **4.4 [The Criminal Justice and Courts Act 2015](#)**

Against the background of the Francis Report and the prosecutions arising from Winterbourne view, there is now a new criminal offence of ill treatment or willful neglect in health and social care (sections 20 – 25), which came into force on 13 April 2015. This offence mirrors s44 of the Mental Capacity Act 2005, but also covers the ill treatment or willful neglect of persons who has mental capacity and it is applicable to both individual care workers and provider organizations.

### **4.5 Duty of Candour. Health & Social Care Act 2008 (Regulated Activities), Regulations 2014: Regulation 20. ([Regulation 20: Duty of Candour](#))**

The responsibility for duty of candour lies with all Health and Social Care Providers registered with the Care Quality Commission (CQC). Its implementation follows recommendations identified following the Francis Report (2014).

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment. This includes the provision of all necessary support and relevant truthful information in the event that a 'reportable patient safety incident' occurs. A 'reportable patient safety incident' is one which could have or did result in moderate or severe harm or death. This also includes the provision of an apology when things go wrong.

Care organisations also have a duty to inform commissioners where the duty of candour requirement has been instigated and will therefore report safeguarding concerns in an open and transparent way; assisting in any investigation that is carried out especially if it is indicated that the pressure ulcer may have been avoidable and/or that neglect is suspected.

The Nursing and Midwifery Code of Conduct is also clear regarding professional responsibilities and duty of care.

## **PART 2: PRACTICE GUIDANCE AND SAFEGUARDING PROCEDURES**

### **5. What does good practice look like?**

**The Department of Health and Social Care's definition of avoidable/unavoidable should not be used.**

**All pressure ulcers, including those that are considered avoidable and unavoidable, should be incorporated in local PU monitoring.**

It is widely accepted that the majority of pressure ulcers are, for the most part, avoidable. It is recognised however, that there are situations where the development of a pressure ulcer is unavoidable. The following guidance is taken from the NPSA (2010; Defining Avoidable and Unavoidable Pressure Ulcers)

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

- *Evaluate the person's clinical condition and pressure ulcer risk factors;*
- *Plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice;*
- *If the patient has refused care or the carer has refused to deliver care and the 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.*

The guidance goes onto provide the definition of an unavoidable pressure ulcer as:

*'Unavoidable' means that the person receiving care developed a pressure ulcer even though the provider of the care had:*

- *Evaluated the 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; and revised the approaches as appropriate; or*
- *The individual person refused to adhere to the prevention strategies even though they had been educated and fully informed of the consequences of their choices*

Neglect, in the context of pressure ulcer management and adults at risk in this protocol will be defined as:



‘The deliberate withholding or unintentional failure to provide appropriate care and support, has resulted in, or is highly likely to result in (when considering other adults at risk in the same situation), a preventable pressure ulcer’.

## 5.1 Assessment and Documentation

Where health and social care professionals have responsibility for the care of individuals in hospital and/or the community, appropriate documentation should be completed assessing skin integrity and pressure ulcer risk when first seen and on an on-going basis where a risk has been identified. The assessment and plan of care should be documented and re-evaluated to reflect changes in the individual's condition. Good practice should include a nutritional assessment and a 24 hour positioning plan, if assistance with repositioning is required. Appropriate pressure relieving equipment should be provided and documented

If there is a pressure ulcer / deep tissue injury present a comprehensive wound assessment should also be undertaken. This will include:

- Site and category of each pressure ulcer using the EPUAP (2014) classification system (**Appendix 2**)
- Wound dimensions (length/width/depth/undermining)
- Type of tissue in wound bed
- Wound exudate levels and type
- Signs of wound infection
- Condition of skin surrounding ulcers
- Documentation of treatment plan
- Appropriate use of dressings with rationale for choice
- Evidence of evaluation and reassessment

Where an adult at risk in the care of Community Services or a Care Home requires transfer into another health or social care establishment (for example: a care home or hospital), **staff should ensure where able, completion in full of the “condition of skin” transfer form (Appendix 3)** providing details of any marks on the skin or pressure ulcers present, risk management details, treatment and interventions up until the point of transfer and assessment details of the individuals mental capacity. This may be easier to complete for planned transfers, but when in emergency or when no trained medical staff present, it is good practice for staff to ensure there is some record transferring with the individual and a copy held in their care records. The following hyperlink provides further information. ([NICE Guidance \(2015\): Transition between in patient hospital settings and community or care home settings for adults with social care needs](#))

This will assist the receiving health or social care establishment in their own assessment and gathering of information and help to prevent inappropriate referrals into the Safeguarding Adults process.

Where an adult at risk has mental capacity and chooses not to engage/accept interventions (treatment/care and/or appropriate pressure relieving equipment) with regard to either the risk of developing pressure ulcers or the care of existing pressure ulcers, the individual should be fully informed of the risks associated with their choice and the implications that this could have on their health.

The professional undertaking this must escalate these concerns within their management structure and seek further support and advice. A record must be documented in the individual's notes that they have capacity and understand their decision.

In conjunction with this, a risk assessment must also be completed (in line with the organisational Risk Management Policy) that fully documents the risks and implications of not engaging with recommended care and treatment. This assessment may be key in helping to determine whether neglect has occurred and will need to be regularly reviewed. Consideration should be given to implementing the B&NES Safeguarding Adults Multi-Agency Self-Neglect Guidance if this is indicated

## **5.2 Current tools used to identify “at risk” individuals and categorise the severity of pressure ulcers**

There are various assessment tools and guidelines which assist with the identification and management of those people at risk of developing pressure ulcers.

- All organisations should have their own up to date Pressure Ulcer Prevention and Management Guidelines with a validated risk assessment tool.
- Categorisation of ulcers should be recorded using the European Pressure Ulcer Classification System (2014) as recommended by NICE 2014 **(Appendix 2)**
- [The Malnutrition Universal Screening Tool \(MUST\)](#)
- All organisations should have guidance on Non-Concordance with Care and or Treatment

Health and Social Care professionals must be able to evidence Pressure Ulcer Prevention and Management and Wound Care training appropriate to their role. They must also be able to evidence continued professional development through appraisals and supervision

## **6. Notification - Safeguarding and Governance Arrangements**

All pressure ulcers must be considered as requiring early intervention to prevent further damage. If there are concerns regarding poor practice, an appropriate escalation must be considered. A referral should be made into the B&NES Safeguarding Adults Procedures if there is:

- Significant skin damage, for example; category 3 or 4, ungradable, deep tissue injury, or multiple category 2 pressure ulcers (as defined by the EPUAP Quick Reference Guide 2014 - [EPUAP: Prevention and treatment of pressure ulcers](#))
- There are reasonable grounds to suspect that it was preventable, or
- That inadequate measures were taken to prevent the development of the pressure ulcer, or
- There is inadequate evidence to demonstrate the above.

Any pressure ulcers at category 2 and above MUST be reported as an adverse clinical incident according to local governance procedures. It should be noted that

all category 3 and 4 pressure ulcers are reportable to NHS BaNES CCG as a Serious Incident (SI)

Under the Health & Social Care Act (2008), Outcome 20 (Notification of Incidents) in the CQC Guidance about Compliance – Essential Standards of Quality and Safety, the Registered Person (this now includes NHS, Adult Social Care & Independent Health) must notify CQC of '*the development after admission of a pressure sore of grade 3 or above that develops after the person has started to use the service (EPUAP Grading)*'. ([Summary of Regulations, Outcomes and Judgement Framework](#)) The definition of a pressure ulcer on admission (POA) should be that it is observed during the skin assessment undertaken on admission to that service (Pressure Ulcers: revised definition and measurement, June 2018).

## **7. How to determine if a pressure ulcer is due to neglect of an adult at risk.**

### **7.1 Assess if there is a problem?**

Where tissue viability is a concern and the adult at risk lives in their own home or a Care Home (providing social care/residential), concerns may first be identified by a carer (either formal or informal), who can refer to an appropriate health professional (e.g. GP, Practice Nurse or Community Nurse) for assessment and treatment. The health community can provide information to informal carers on how to identify possible skin care problems and how these can be treated with appropriate specialist support once these have been identified.

Hospitals and Care Homes providing nursing care employ Registered Nurses with the relevant skills and knowledge to undertake assessment of the risk of pressure ulcer development and manage treatment. The additional support of more specialist intervention such as a tissue viability nurse maybe required to manage care and treatment both in a hospital and community setting.

Where Health or Social Care staff identify or receive concerns in respect of a pressure ulcer they must ensure that an assessment of the individual and their care takes place by a health care professional – a Registered Nurse/District Nurse and/or a Tissue Viability Nurse (depending upon the complexity of the wound) who has the appropriate skills and knowledge to undertake this assessment.

The health care professional undertaking the assessment will consider the level of risk, establish how their care has been delivered and review information already gathered to assess if all reasonable steps have been taken to prevent the pressure ulcer. The care that was given should be assessed against available local and national guidance. A second opinion/referral to the Tissue Viability Nurse (TVN) should be sought especially where there are multiple category 2, or category 3 or 4 pressure ulcers present. The TVN (hospital/community) will complete a screening assessment (**Appendix 4**) as part of any safeguarding referral to help determine whether safeguarding procedures are required.

## 7.2 Is there evidence of neglect?

Not all pressure ulcers are the result of neglect.

Relevant factors to consider:

- The individual's compliance/behaviour that might impact on appropriate care being given.
- Other co-morbidities such as chronic disease and palliative care
- Capacity to consent or decline treatment.
- Change in medical condition or end of life care
- History of development of the pressure ulcer
- Health and Social Care staff involvement
- Carer involvement (formal and informal)

In the case of pressure ulcer development, **neglect** is the deliberate withholding **OR** unintentional failure to provide appropriate **OR** adequate care and support, that has resulted in, or is highly likely to result in (when considering other adults at risk in the same situation), a preventable pressure ulcer. It is not the intent that needs to be considered but the level harm that has resulted from the act or omission and which should trigger the multi – agency safeguarding procedures.

Further guidance to support assessment in determining safeguarding concerns can be found in **Appendix 5**

Trigger pathways for individuals who are receiving professional support (for example; in Care Home, hospital, from a Domiciliary Care provider or a nursing agency) and for those individuals who are not receiving any professional care and are looked after by an unpaid carer, family or friend can be found in **Appendix 6**

## 8. Referral into Safeguarding Adults Procedures

The BaNES Multi-Agency Safeguarding Adults Policy & Procedures 2015 places a duty of care on all health and social care staff, statutory and independent sectors, to report allegations, concerns and suspicions of abuse. It is the areas of neglect where the greatest uncertainty often arises with respect to possible abuse. The Safeguarding Procedures are designed to identify whether or not there is abuse within a multi-agency arena – staff do not need to make such judgements on their own.

Referral into the Safeguarding Adults process and the instigation of a discussion and/or Planning Meeting is required when there is a high risk of serious harm being caused by acts or omissions to care in relation to pressure ulcer development and management which could reasonably have been avoided.

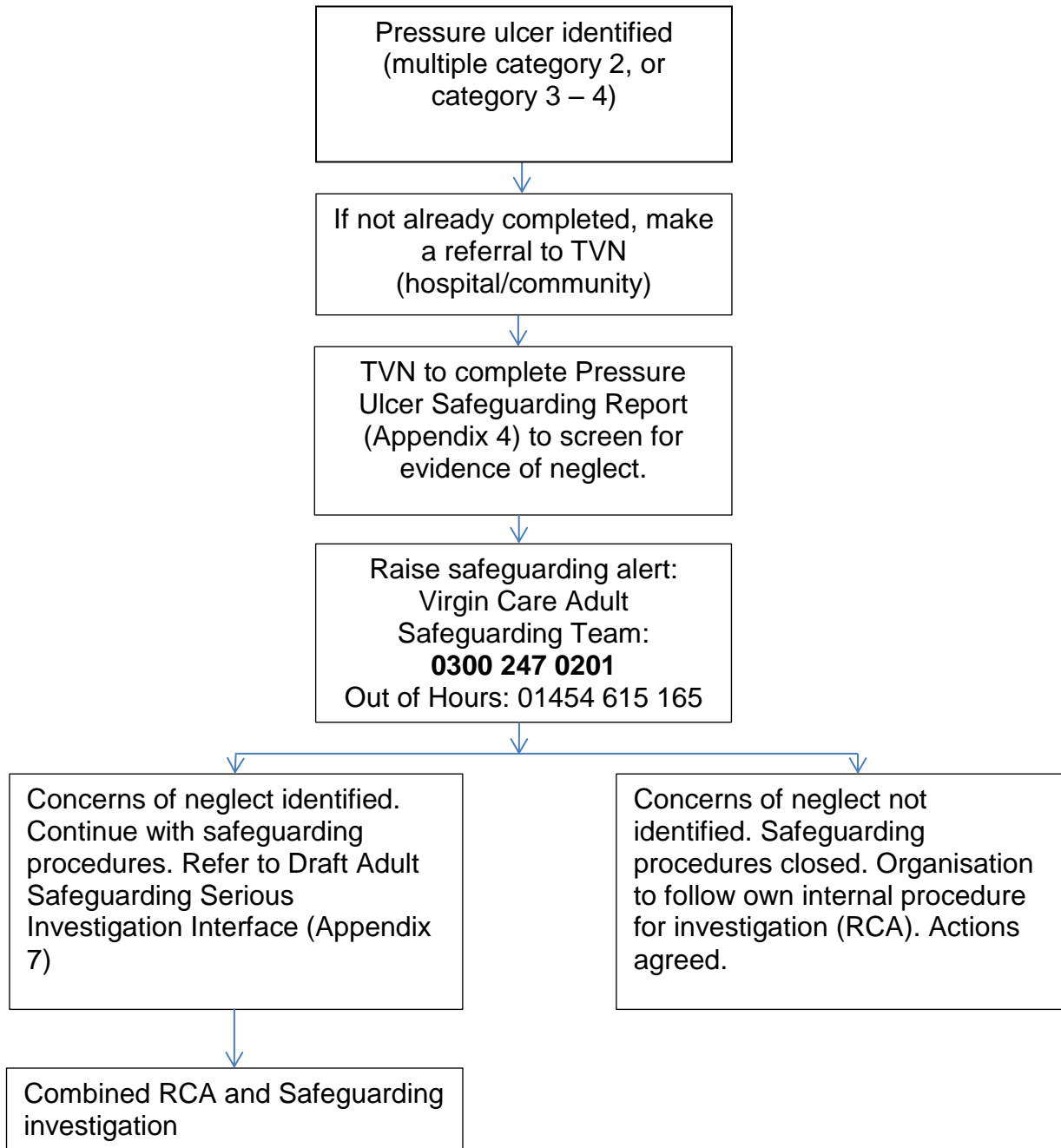
An alert should be made under the B&NES Multi-Agency Safeguarding Adults Procedures to the **Virgin Care Adult Safeguarding Team** by contacting the following telephone numbers:

**From Monday to Friday – 0300 247 0201**

**Out of Hours via the Emergency Duty Team – 01454 615 165**

The following diagram provides guidance to staff on the referral process to raise a safeguarding concern:

**Trigger Pathway to raise safeguarding concern**



## 9. Safeguarding Adults procedures

B&NES Safeguarding Adults Procedures will be instigated where neglect is suspected in the development of a pressure ulcer. The strategy and planning meeting and the development of a protection plan must include all agencies involved with the case agreeing their respective roles and responsibilities with regard to actions/investigation. This must be clearly documented and recorded. An independent clinical professional should support the investigation if appropriate/necessary.

Where a pressure ulcer has developed, and the individual is assessed to lack mental capacity to consent to and engage with assessment, treatment and interventions, the Police must be consulted and a criminal investigation considered under Section 44 of [The Mental Capacity Act 2005](#)

## 10. Investigation

Where Safeguarding Adults procedures are instigated as a result of concerns relating to the development of a pressure ulcer, an investigation is likely to be requested by the Safeguarding Adults Chair to help determine whether neglect has occurred.

In March 2015, NHS England published the 'Serious Incident Framework – Supporting learning to prevent recurrence' ([Serious Incident Framework](#)). The framework details how all organisations providing NHS funded care should report, investigate and monitor serious incidents. The Organisation where the incident requiring investigation occurred has overall responsibility for the investigation and implementation of subsequent action plans. Investigations are conducted using a Root Cause Analysis (RCA), the level of which is determined by the grading of the incident. Timescales for investigation are clearly defined.

The definition of serious incidents requiring investigation is documented within the framework. For the purposes of safeguarding, such an incident may be determined further to an allegation of abuse under the following criteria:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including the community) that result in:
  - Unexpected death of one or more *people (caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omissions) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice)*;
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further health treatment by a healthcare professional in order to prevent:
  - The death of the patient; or serious harm
- Actual or alleged abuse;.....or acts of omission which constitutes neglect.....where:
  - Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring, or; where abuse occurred during the provision of NHS-funded care

- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (MCA DOLS, 2009)

In the case where a patient has a pressure ulcer at Category 3 or 4 (EPUAP 2014), which occurred as part of NHS-funded healthcare, the organisation where the incident occurred will undertake the Root Cause Analysis (RCA). It is acceptable for the RCA to be used as the mode of investigation. Additional Terms of Reference maybe included as part of safeguarding procedures and will be determined and agreed at the Planning Meeting. NHS B&NES will be requested to review the standard and detail of assessment, documentation and evidence of the care regime. An independent clinical opinion will be sought if appropriate.

Where cases are not subject to being reported as a Serious Incident (Care Homes), the Planning Meeting will be used to determine who will undertake this investigation and complete the investigation report. The Safeguarding Adults Lead (NHS BaNES CCG) will support the investigation if this is felt to be appropriate.

**Appendix 7** details the Adult Safeguarding and Serious Incident Investigation Interface and should be followed in conjunction with the BaNES Multi-Agency Safeguarding Policy and Procedures.



## **Appendix 1:**

### **Mental Capacity Act 2005**

#### **Five Key Principles to determine Mental Capacity**

**Principle 1:** A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

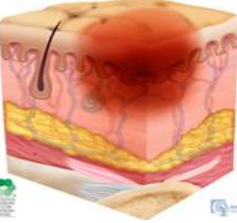







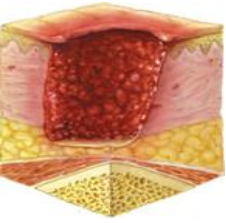



**Principle 2:** Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.


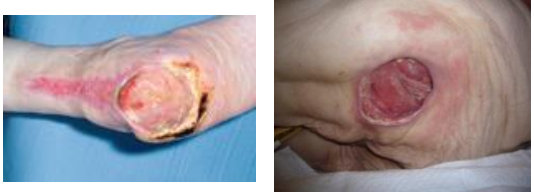

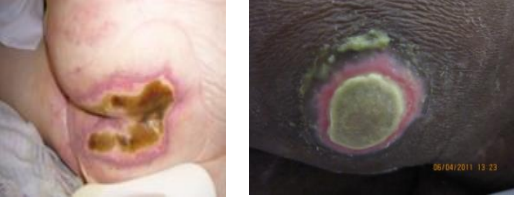

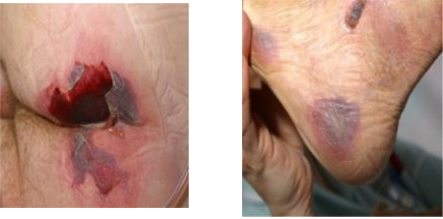


**Principle 3:** Unwise decisions – people have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

**Principle 4:** Best interests – anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

**Principle 5:** Less restrictive option – someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.

This tool should be used in addition to the Pressure Ulcer Prevention Pathway AND Care Plan (EPUAP 2014, NHSi, 2018)

Category	Description	Image guide			
<p><b>Category 1</b></p>	<p><b>Non blanchable erythema</b>                      Intact skin with non-blanchable redness of a localised area. Usually over a bony prominence. Darkly pigmented skin may not have visible blanching, may be blue or purple. May be painful/firm/soft/warm or cool compared to adjacent tissue.</p>	 		 	
<p><b>Category 2</b></p>	<p><b>Partial thickness skin loss</b>                      Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. May also present as an intact or open/ruptured blister. Presents as a shiny or dry shallow ulcer without slough or bruising.</p> <p><i>Do not use this category to describe incontinence associated dermatitis, maceration or excoriation</i></p>	 		 	
<p><b>Category 3</b></p>	<p><b>Full thickness skin / tissue loss</b>                      Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. May include undermining and tunnelling. Slough may be present but does not obscure the depth of tissue loss. Depth varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and category 3 ulcers can be shallow.</p> <p><i>If the depth is obscured – use Unstageable</i></p>	 		 	

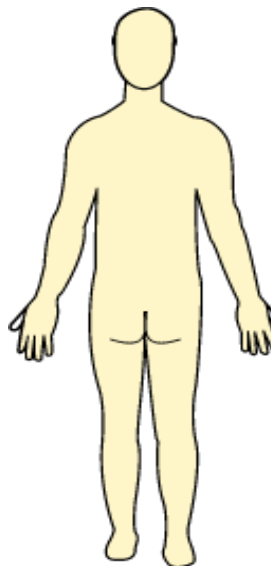
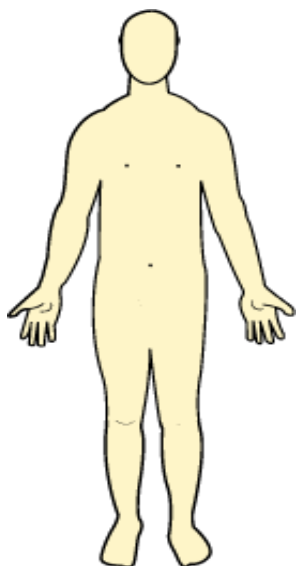
<b>Category 4</b>	<p><b>Full thickness tissue loss</b></p> <p>Exposed bone, tendon or muscle is visible or directly palpable          Slough or eschar may be present on parts of the wound bed          Often includes undermining and tunnelling.          Depth varies by anatomical location.          The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and category 4 ulcers can be shallow.          Category 4 ulcers can extend into muscle and/or supporting structures (fascia/tendon/joint capsule) making osteomyelitis possible.  <i>If the depth is obscured – use Unstageable</i></p>		
<b>Unstageable</b>	<p><b>Depth Unknown</b></p> <p>Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/ or eschar (tan, brown or black).          Until enough slough/eschar is removed to expose the base of the wound, the true depth cannot be determined.          Stable eschar on the heels without infection should not be removed.</p>		
<b>Deep Tissue Injury (DTI)</b>	<p><b>Depth Unknown</b></p> <p>Purple or maroon localised area of discoloured intact skin.          Blood filled blister.          Evolution may be rapid exposing additional layers of tissue even with optimal treatment.</p>		
<b>Device Related Pressure Ulcer</b>	<p><b>Pressure Ulcers that occur under medical devices</b></p> <p>For example: plaster of paris causing damage to heels, oxygen tubing over the ears, face masks over the nose under anti embolic stockings or bandaging.          These can vary in depth according to the site.</p>		

## Appendix 3

### Skin Condition Transfer Form

Surname	
Forename	
DOB	
Address	

On the figures below identify and number any marks or pressure ulcers present on the individuals body and describe in the table. Please also check for any warmth or hardness of tissue over bony prominences.



Pressure ulcer or marks Tissue warmth or hardness	Description/Dimensions EPUAP Category if a pressure ulcer	How and where mark or ulcer developed if known	Details of any current treatment
1.			
2.			
3.			
4.			
5.			

Please document here if the individual refuses assessment of any parts of the body:

Please document any relevant information regarding mental capacity:

Waterlow Score (if used):

Transfer form completed by:

Name and contact  
number.....

Designation.....  
.....

Date.....  
.....

**Appendix 4**

**PRESSURE ULCER SAFEGUARDING REPORT**

To be completed by TVN.

All category 3 and 4 pressure ulcers must be screened for evidence of neglect.

Patient Name	Date of Birth	MRN	Ward
Site and category of pressure ulcer(s)		Package of care	
Is the person an Adult at risk as defined in The Care Act (2015)?			
Evidence of care implemented to prevent	YES	NO	Comments if required
Risk assessment			
Reassessment of risk assessment			
Care plan in situ with appropriate strategies			
Evaluation of strategies			
Monitoring of wound progress			
Appropriate equipment in situ			
MUST risk assessment			Dietitian referral?
Repositioning as plan and documented			
Evidence of skin inspection			
<b>Evidence of neglect</b>			
Care planning not robust			
Equipment not considered			
Faulty equipment			
Incorrect /Incomplete risk assessment			

Background Summary (setting the scene and to cover any capacity or concordance issues)

Evidence of neglect	Care provider of which there are concerns

As a Tissue Viability Nurse Specialist I recommend that a safeguarding Planning Meeting **IS NOT** convened as there **IS NOT** evidence of neglect.

	Name	Job Title	Date
Assessor			
Reader			

## **Appendix 5**

### **GUIDANCE FOR HEALTH & SOCIAL CARE STAFF TO ASSIST IN DETERMINING SAFEGUARDING CONCERNS**

#### ***Patient history:***

- Whether rapid onset and deterioration to a severe ulcer
- Patient compliance and behaviour
- Mental capacity to consent to treatment and intervention
- Whether extensive damage to a low risk patient

#### ***Co-morbidity:***

- Medical history
- Chronic disease
- Palliative care
- Mental health issues or cognitive impairment

#### ***Indicators of neglect:***

Is the person's physical appearance poor?

Consider:

- General appearance.
- Hygiene.
- Dirty nails.
- Poor oral hygiene.
- Soiled or wet clothing.

#### ***Is there evidence of poor quality care?***

Consider whether reasonable measures have been taken to prevent tissue damage. Absence of any of the following may indicate a safeguarding referral but will need to be assessed on an individual basis

- Implementation and evidence of a 24 hour approach of a repositioning regime with clear supporting documentation
- Regular skin inspection and clear documentation to include continence management and protection of skin.
- Standard of assessment and the use of relevant policy and procedures to support care plan.
- Evidence of identification and management of risk factors for pressure ulcer development.
- Whether appropriate equipment has been provided
- Evidence of appropriate plan of care, which is updated accordingly and addresses the cause of pressure damage. This should include appropriate preventative and treatment regime.



- Nutritional assessment, involvement of appropriate professionals and implementation of associated care plan (the use of the Malnutrition Universal Screening Tool is recognised as good practice). Evidence of intake monitoring, fluid balance, regular weighing
- Evidence of risk management.
- History of recurrent pressure ulcers.
- Evidence of appropriate wound assessment and dressing selection (with rationale for choice).
- Assessment of mental capacity where indicated and documented evidence of offering care to non-concordance
- Evidence of appropriate use of medication analgesia and/or sedation.
  - Note use of sedation if patient is immobile for extended periods
  - If pain has been assessed and is being managed

### **Key questions to ask that apply to all settings.**

- Where no monitoring has taken place prior to the development of a pressure ulcer, should the illness, behaviour or disability of the adult at risk have reasonably required the monitoring/treatment of the skin condition?
- If the monitoring / treatment of the skin condition were then refused by the adult / family, was it reasonable for advice to be sought?

The adult's consent to monitoring should always be sought and documented, but if the person lacks mental capacity to make a decision regarding care or treatment a decision must be taken to act in the best interests of the individual utilizing the MCA.

Where there is no representation for the vulnerable adult who lacks mental capacity, a referral should be made to the IMCA service (Independent Mental Capacity Advisor). The family have no right to refuse treatment or monitoring.

If a person who lacks mental capacity has an Advanced Directive ([add in hyperlink](#)), staff should respond accordingly to the pre-determined wishes of the individual.

- If monitoring / treatment of the skin condition were agreed, was the frequency of the monitoring / treatment appropriate for the condition as presented at the time?
- Would monitoring have shown changes in presentation of the skin (e.g. persistent change in colour, temperature of skin etc.) that should have triggered the need for intervention or the seeking of more expert assistance that would have prevented serious harm or its high likelihood?
- Was appropriate expert advice sought? If so did this result in a plan appropriate to address the pressure needs of the adult at risk?
- Was the care plan adhered to and evaluated properly?
- Was equipment provided in a timely manner and used appropriately?

## **Appendix 6: Pressure Ulcers – Safeguarding Triggers: Pathway 1**

To determine if the identification of a pressure ulcer on an individual receiving professional support (in a care home, hospital or from domiciliary care of nursing agency care) should result in a safeguarding referral the following triggers should be considered.

**IF IN DOUBT** → Initiate Safeguarding Adults Procedures → Record decision and reasons for decision.

	<b>Possibly NOT Safeguarding at this stage</b>	<b>Possibly Safeguarding</b>	<b>Definitely Safeguarding</b>
1. What is the severity (category) of the pressure ulcer?	Category 2 pressure ulcer or below – care plan required	Several category 2 pressure ulcers/ category 3 to 4 pressure ulcers- consider question 2	Category 4 and other issues of significant concern
1. Does the individual have mental capacity and have they been compliant with treatment?  Has a capacity assessment been completed?	Has capacity and declined treatment  Capacity assessment is recorded.	Does not have capacity or capacity has not been assessed- continue to question 3  Where the person has mental capacity but there are concerns of non-concordance with care and/or treatment and this has not been properly assessed / documented.	Assessed as NOT having capacity and treatment NOT provided  →
3. Full assessment completed and care plan developed in a timely manner and care plan implemented?	Documentation and equipment available to demonstrate full assessment completed, care plan developed and implemented.	Documentation and equipment NOT fully available to demonstrate full assessment completed, care plan developed or care plan implemented BUT general care regime (e.g. nutrition, hydration) not of concern- continue to question 4	Little or no documentation available to demonstrate a full assessment has been completed, or care plan implemented AND general care regime (e.g. nutrition, hydration) is of concern.
4. This incident is part of a trend or pattern- there have been other similar incidents with this individual or others.	Evidence suggests this is an isolated incident.	There have been other similar incidents	Evidence demonstrates this is a pattern or trend.
	<b>NOT SAFEGUARDING</b>	<b>If 2 or more of the above apply - SAFEGUARDING</b>	<b>SAFEGUARDING</b>

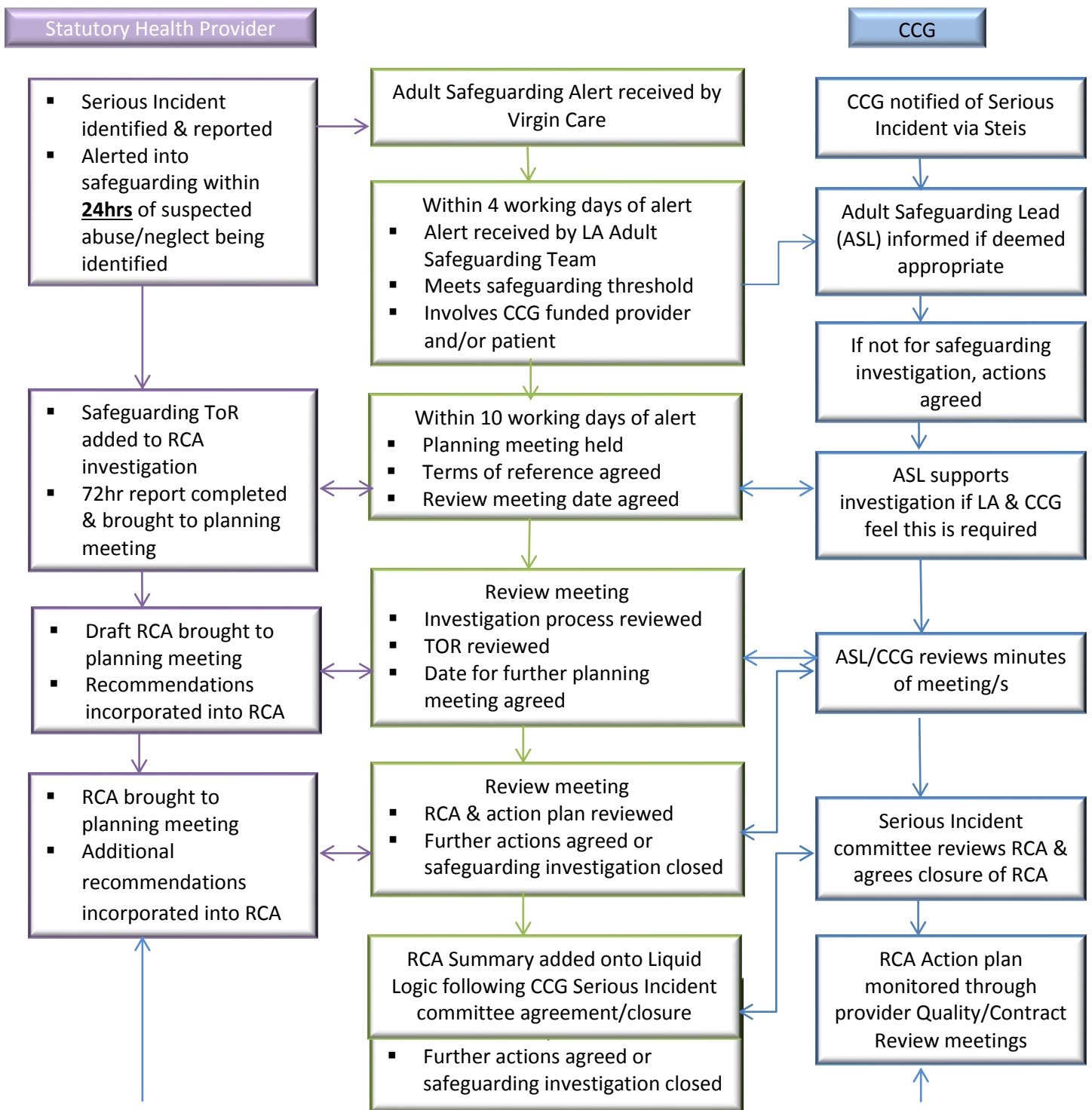
## **Appendix 6: Pressure Ulcers – Safeguarding Triggers: Pathway 2**

To determine if the identification of a pressure ulcer on an individual with NO professional support (i.e. the only support available is from an unpaid carer/ family member) should result in a safeguarding referral the following steps should be considered.

**IF IN DOUBT** → Initiate Safeguarding Adults Procedures → Record decision and reasons for decision.

	Possibly NOT Safeguarding at this stage	Possibly Safeguarding	Definitely Safeguarding
1. What is the severity (Category) of the pressure ulcer?	Category 2 pressure ulcer or below – care plan required	Several Category 2 pressure ulcers/ category 3 to 4 pressure ulcers- consider question 2	Category 4 and other issues of significant concern
2. Does the individual have mental capacity and have they been compliant with treatment?  Has a capacity assessment been completed?	Has capacity and declined treatment  Capacity assessment is recorded.	Does not have capacity or capacity has not been assessed- continue to question 3	Assessed as NOT having capacity and treatment NOT provided
3. Unpaid carer raised concerns and sought support at an appropriate time.	Evidence available to show concerns raised and support sought – e.g. from GP, DN, SW.	Evidence NOT CLEAR that concerns were raised or support sought in a timely manner.	No support sought
4. Full assessment completed and care plan developed in a timely manner and care plan implemented?	Evidence available to show unpaid carer cooperated with assessment and has implemented care plan	Evidence of partial cooperation or implementation of care plan- some aspects may have been declined e.g. certain equipment.	NO cooperation and refusal to implement care plan and or purposeful neglect.
5. This incident is part of a trend or pattern – there have been other similar incidents or other areas of concern	Evidence suggests that this is an isolated incident	There have been other similar incidents or other areas of concern	Evidence demonstrates that this is a pattern or trend.
	<b>NOT SAFEGUARDING</b>	<b>If 2 or more of the above apply Safeguarding</b>	<b>SAFEGUARDING</b>

## Appendix 7: DRAFT Adult Safeguarding & Serious Incident Investigation Interface



### SERIOUS INCIDENT TIMESCALES

1. Professional Review Meeting within 72hrs
2. Investigation to be completed within 60 working days/12 weeks from date incident reported

### SAFEGUARDING TIMESCALES

1. Alert raised within 24hrs of incident being identified
2. Planning Meeting within 10 working days of alert
3. Complete Section 42 Enquiry and take to Safeguarding Review Meeting in timescale agreed with Safeguarding Team

Timescales may vary depending on the concerns and level of risk identified.