Appendix 4 Pressure ulcers and neglect: making a decision whether to refer to adult safeguarding

The purpose of specific guidance is to protect adults at risk by providing a framework to guide health and social care staff and agencies on whether safeguarding procedures should be instigated when concerns have been raised that a pressure ulcer may have developed as a result of neglect or poor care practice.

This guidance will enable health and social care staff to identify if it is likely the pressure ulcer was caused as a result of neglect, or poor care practice and whether an investigation under the safeguarding procedures should take place. It will provide a focus on thresholds for referral through the safeguarding adult process.

This guidance applies to all health and social care staff in Hertfordshire who work with adults at risk and develop a pressure ulcer or are at risk of developing a pressure ulcer.

Pressure ulcers

‘A pressure ulcer is defined as a localised injury to the skin and or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with sheer’ (NPUAP, EPUAP, PPPIA 2014).

‘All patients (or those people with care needs) are potentially at risk of developing a pressure ulcer. However, PU are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Also, the use of equipment such as seating or beds which are not specifically designed to provide pressure relief can cause pressure ulcers. As pressure ulcers can arise in a number of ways, interventions for prevention and treatment need to be applicable across a wide range of settings including community and secondary care’ (NICE 2014).

Pressure ulcers are often preventable (NICE 2014) and their prevention and reducing the risk of avoidable harm to patients is an important part of health and social care, as detailed in Domain 5 of the NHS outcome framework 2016/17 (DH 2016).

It should also be recognised, however, that not all tissue/skin damage is a pressure ulcer and there may be other explanations for the tissue/skin damage e.g. friction damage, moisture lesion, ischaemic ulcers. It is important therefore to obtain clinical opinion on the nature and causation of the tissue/skin damage to clarify the type of wound which is present.

Specific guidance on neglect or poor care practice relating to pressure ulcers

Pressure ulcers are costly in terms of both patient suffering and the use of resources. It is widely accepted that pressure ulcers are, for the most part, preventable if:

- the circumstances which are likely to result in pressure ulcers are recognised
- those at risk are identified early
- appropriate prevention measures are implemented without delay

Pressure ulcers can occur in any individual but are more likely in high risk groups. To consider whether the pressure ulcer has developed in terms of neglect/acts of omission or poor practice from care providers requires an understanding that the pressure ulcer was avoidable. NHS England has defined unavoidable and avoidable PU as follows: (NHS England 2016):
Unavoidable
A pressure ulcer developed despite the care provider evaluating the patient's clinical condition and pressure ulcer risk factors and developing an appropriate preventative plan of care
- Monitoring and evaluating the impact of the interventions and revising the intervention as appropriate
- The patient (or person) chose not to adhere to the prevention strategies despite being fully informed of the possible consequences

Avoidable
The person providing care did not:
- Evaluate the patient's clinical condition and identify pressure ulcer risk factors
- Plan and implement interventions consistent with the patients' needs and goals and recognised standards of practice
- Monitor and evaluate the impact of the interventions and revise the interventions as appropriate
- Reasons for refusing care have not been explored and risks not adequately explained

If the pressure ulcer (or other skin/tissue damage) is believed to have been caused by neglect, or organisational abuse, it should be reported as an adult safeguarding concern.

Care homes regulated by the CQC are required to inform CQC, via a regulation 18 notification, of a category 3 or 4 pressure ulcer which has developed after the resident started to use their service (CQC 2015).

NHS commissioned organisations are required to investigate category 3 and 4 pressure ulcers under the policy/framework agreed by the CCG with an NHS organisation and, if appropriate, consider or undertake investigations within the NHS serious incident framework (NHS England 2015).

Neglect, poor care practice and organisational abuse

In the context of adult safeguarding and pressure ulcers neglect or organisational abuse refers to:
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
- the withholding of the necessities of life, such as medication, adequate nutrition and

The Care Act statutory guidance indicates that the circumstances surrounding any actual or suspected case of abuse or neglect will inform the response to be taken and who is best
placed to lead on the response or the investigation. For example, with pressure ulcers it may be more appropriate for the NHS service or care organisation to investigate the circumstances or undertake a Root Cause Analysis to establish if the PU was unavoidable or avoidable and consider what response is required. This may include taking actions to improve care practice or address the practice deficits of individual staff. It may also include actions being taken with organisations by the commissioning or regulatory bodies (DH 2016).

**Current tools used to identify ‘at risk’ individuals and categorise the severity of pressure ulcers**

There are various validated assessment tools which organisations should utilise as part of developing a person’s care plan to assist with the identification and management of those people at risk of developing pressure ulcers (NICE 2014). These include:

- Pressure ulcer prevention and management guidelines. These may require reference and an escalation process to a NHS organisation e.g. from residential care homes to the District Nursing Service
- a risk assessment tool e.g. Waterlow Score, Braden Scale or Norton Risk assessment scale
- categorisation of ulcers should be recorded using the European Pressure Ulcer Classification System (EPUAP 2014)
- the Malnutrition Universal Screening Tool (MUST)

Where an adult at risk requires transfer into another health or social care establishment staff will be expected to complete a skin condition transfer form, body map or ‘Nursing Transfer’ letter.

**Mental Capacity Act and pressure ulcer prevention**

Where the person, or patient, lacks mental capacity to consent to or comply with pressure ulcer preventative measures care providers will need to develop preventative care plans to minimise the risk of harm occurring. In care planning care providers will need to take account of the Mental Capacity Act and, where appropriate, Deprivation of Liberty Safeguards (UK 2007 & 2009).

**Procedure**

**Five steps to determine if a pressure ulcer is due to neglect of an adult at risk**

**Step one:**

**Assess if there is a problem**

Where there are concerns regarding potential or actual pressure ulcers the adult at risk will require an assessment and treatment from a health professional to identify skin care issues.

**Step two:**

a) **The questions for the health or care professional to ask and which apply to all settings are:**

- Should the illness, behaviour or disability of the adult at risk have reasonably required the monitoring of skin condition (where no monitoring has taken place prior to serious pressure ulcers occurring)?
- If the treatment of the skin condition was then refused by the adult at risk was it reasonable for specialist advice to be sought i.e. HPFT seeking specialist advice from HCT.

- If monitoring was then refused by the adult at risk/family was it reasonable for advice to be sought? The adults at risk consent to monitoring should always be sought but if the person lacks mental capacity to make a decision regarding this, a decision will need to be taken in their best interests. The family has no right to refuse monitoring.

- If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?

- Would monitoring have shown changes in the 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 the appropriate expert assistance sought? If so did that result in a care plan/equipment provision appropriate to address the pressure care needs of the adult at risk? Did the care plan address the management of risks that should have reasonably been identified? (E.g. the high risk of non-compliance by the service user or informal carer?)

- Was the care plan adhered to and revised appropriately? Was the equipment provided in a timely manner and used appropriately?

b) **Consider these three specific questions**

If the answer to the three specific questions below is yes, then a safeguarding adult concern should be made under the Safeguarding Adults from Abuse procedures [http://www.hertfordshire.gov.uk/your-council/hcc/healthcomservices/acspolicies/safeadults/](http://www.hertfordshire.gov.uk/your-council/hcc/healthcomservices/acspolicies/safeadults/)

<table>
<thead>
<tr>
<th>Question 1</th>
<th>Is there an adult safeguarding concern?</th>
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<tbody>
<tr>
<td>‘Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect’ Care Act 2014. This applies to adults who have care and support needs (whether or not the LA 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</td>
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<tr>
<th>Question 2</th>
<th>Is there evidence of neglect?</th>
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<td>Relevant factors to consider:</td>
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<tr>
<td>• the individuals compliance / behaviour that might impact on appropriate care being given</td>
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<td>• other co-morbidities such as chronic disease and palliative care</td>
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<td>• mental capacity to consent or decline treatment</td>
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<td>• health and social care involvement</td>
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<td>• carer involvement</td>
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<td>• determining whether the pressure ulcer/damage is avoidable</td>
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<th>Question 3</th>
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<td>• review the information already gathered</td>
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Are there concerns that all reasonable steps have not been taken to prevent the pressure ulcer or tissue damage?  
- circumstances of neglect should be considered
- a judgement maybe required about whether an act or an omission to act has caused significant harm
- second opinion may be considered e.g. TVN or Safeguarding Adult Lead
- determining if pressure ulcer/damage was avoidable

Guidance note  
The assessment should include
- When did the PU/tissue damage start to develop
- Patient’s/person’s clinical history
- history of compromised skin integrity
- co-morbidities
- indicators of neglect e.g. is the person’s physical appearance poor
- consider evidence of poor quality care
- standard of assessment and use of relevant policy/assessment tools
- evidence of identification and management of risk factors
- evidence of implementation of preventative care plan
- evidence that regular reassessment of care plan has been carried out and implemented
- evidence of a continence plan
- predisposing factors e.g. moisture lesion, sheer or friction daman
- evidence of appropriate prevention and treatment plan including the consideration of appropriate pressure relieving equipment’
Skin Condition Transfer Form

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Date of Birth</th>
<th>Address</th>
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On the figures below identify and number any tissue damage, marks, or pressure ulcers present on the individual’s body and describe in the table. Please also check for any warmth or hardness of tissue over bony prominences.

<table>
<thead>
<tr>
<th>Pressure ulcer or marks</th>
<th>Description/Dimensions</th>
<th>How and where mark or ulcer developed if known</th>
<th>Details of any current treatment</th>
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<tbody>
<tr>
<td>Tissue warmth or hardness</td>
<td>EPUAP Category if a pressure ulcer</td>
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Please document here if the individual refuses assessment of any parts of the body:

Please document any relevant information regarding mental capacity:

Waterlow Score:

Transfer form completed by:
Name and contact number:
Designation:
Date:
References


