Safeguarding Adults Pressure Ulcer Protocol: Deciding whether to do a Safeguarding Adult referral.
Safeguarding Adults and Pressure Ulcer Protocol: Deciding whether to refer to the Safeguarding Adults Procedures

To date the government has advised that anyone who develops grade 3, grade 4 or ungradable pressure ulcers be referred as a safeguarding risk. The analysis of the referrals has shown that only about 20% of all referrals go on to require investigation. The documentation required to report someone as a possible safeguarding risk is lengthy so this decision making tool has been developed to ensure only people who do require investigation are reported. Using this tool will ensure it will only be necessary to complete a safeguarding alert if the tool shows the person is deemed at risk of abuse.

What is Safeguarding?
The government’s statement on safeguarding advises that everyone has a responsibility, including the general public, to safeguard people against poor practice, harm and abuse. It is the providers’ core responsibility, across health and social care, to provide safe, effective and high quality care. This decision making tool assists a provider in deciding if the person has developed a pressure ulcer as a result of neglect or abuse.

1.0 Aim of Protocol and Introduction

1.1. The government’s statement on safeguarding (2013) advises that distinctions need to be drawn between where there are concerns about the quality of the service provided and where there are safeguarding concerns.

1.2. This is a multi-agency protocol including decision guide which 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.

1.3. 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 in Appendix 1.

1.4. From a governance perspective each organisation will be responsible for ensuring that the protocol is used appropriately along with monitoring and reviewing its use.

1.5. 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.

1.6. Skin damage has a number of causes, some relating to the individual person, 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

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1 Statement of Government Policy on Adult Safeguarding May 2013
2 The term staff is used to refer to employees from all sectors.
3 Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse – SCIE report 39-2011
considered. All cases of actual or suspected neglect should be referred through the safeguarding procedures via Haringey Safeguarding Adults reporting process. This can be done by filling out a referral form. Click on the link to open referral form. [http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults#whocanhelp](http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults#whocanhelp) or via telephone by calling Haringey Integrated Access Team (IAT)

1.7. Haringey Integrated Access Team (IAT) Contact details:

By email to: iat@haringey.gov.uk
By telephone to: 020 8489 1400: 24hrs services 7days a week
By FAX to: 020 8489 4900
By SMS: text IAT to 80818

1.8. **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, i.e. raising a clinical incident.**

1.9. The person should have a safeguarding referral made to Haringey Social Services if there is:

- Significant skin damage (i.e. category/grade 3 or 4, un-stageable, un-gradable, deep tissue injury ulceration or multiple grade 2 pressure ulcers).
- There are reasonable grounds to suspect that it was preventable or
- Inadequate measures taken to prevent the development of pressure ulcer⁴, or
- Inadequate evidence to demonstrate the above


1.11. This protocol should be applied to pressure ulcers reported by anyone including carers, relatives and patients, as any tissue damage no matter who reports it should be investigated

1.12. Where concerns are raised regarding skin damage there is a need to decide if a safeguarding referral is required in addition to the clinical incident form. This includes history taking, contacting former care providers for information if the person’s care has recently been transferred, and seeks clarification about the cause of the damage.

**NHS Arrangements**

1.13. Any category/grade 2 and above pressure ulcer MUST be reported as a clinical incident according to local clinical governance procedures.

**Should pressure ulcers be reported as Serious Incidents? From the NHS England Serious Incident Framework 2015/16 – frequently asked questions**

1.14 Where the definition of a Serious Incident is met, the incident should be reported and investigated according to the principles set out in the Serious Incident Framework.

⁴ With reference to the NICE guideline 29 and local policies
Often organisations report all category 3 and 4 pressure ulcers as Serious Incidents. Clearly some will meet the definition but categorising all category 3 and 4 pressure ulcers as Serious Incidents may lead to a “burden of investigation that makes it difficult to move forward quickly and implement learning”. **Consideration must be given to the circumstances of each case since the category of a pressure ulcer does not always indicate the severity of the wound.** For example, an infected category 2 pressure ulcer may lead to septicaemia and death whereas a very small category 3 pressure ulcer on the ear (designated as category 3 because cartilage will be exposed with any loss of overlying skin) may not have serious consequences for the patient.

1.15 Grading pressure ulcers can also be difficult, particularly when differentiating between a category 2 and 3 pressure ulcer and also between a category 3 and 4. **This is another reason why grading alone should not be relied on for determining overall severity.**

1.16 Any pressure ulcer that meets, or potentially meets, the threshold of a Serious Incident should be thoroughly investigated to ensure any problems in care are identified, understood and resolved to prevent the likelihood of future recurrence. This requires an assessment of whether any acts of omission or commission may have led to the pressure ulcer developing. It is not acceptable to locally define, in advance, certain types of pressure ulcer that are ‘unavoidable’ as long as some routine preventative measures have been undertaken. Any Serious Incident investigation which seeks to conclude that an incident was either ‘avoidable’ or ‘unavoidable’ rather than focusing what could be learned to prevent future harm is not compliant with Root Cause Analysis (RCA) methodology.

**Haringey CCG Incident & Serious Incident Policy/Procedure**

**Pressure Ulcer Safeguarding Decisions**

1.17 Safeguarding decisions need to be made at the following stages of investigation: i) if there are immediate concerns on identification of a pressure ulcer ii) following completion of the ‘Safeguarding Adults Pressure Ulcer (SAPU) Deciding whether to do a safeguarding referral decision guide’ (HCCG, 2015) and iii) following completion of a root cause analysis investigation (RCA) the SAPU decision guide will need to be applied again. All Grade 3 and 4 and multiple 2 Pressure Ulcers will require an RCA to be completed within 10 working days. At the end of the RCA the SAPU decision guide (HCCG, 2015) will need to be applied. If the score is 15 or above (i.e. the pressure ulcer is avoidable) then a safeguarding referral should be made and STEIS notification completed. Any Serious Incident (SI) investigation that meets the criteria for SI reporting needs to be completed within 60 days of the incident occurring.

**Definitions**

1.18 **Unavoidable Pressure Ulcer:** “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 prevention strategies in spite of education of the consequences of non-adherence.” Unavoidable PU do NOT need to be reported on STEIS

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

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evaluate the person’s clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the person’s needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.” Avoidable PU DO need a STEIS notification AND Safeguarding referral.  

1.20 Incipient pressure ulcers as recognised:
“Patients admitted or transferred to a healthcare setting without any obvious signs or symptoms of pressure area skin damage, the development of a pressure ulcer grade 3 or 4 within 72 hours is likely to be related to pre-existing damage incurred prior to admission or transfer of care. For any pressure area damage arising thereafter, the most likely cause will be related to care within the healthcare setting the patient is/are in; this must be regarded as a new event.” (Reference: Nurse Sensitive outcome indicators for NHS provided care. Version 2, March 2010, NHS London)

All hospitals and community care organisations should body map all patients before transfers, on sending or receiving a patient from another organisation within 6 hours.

1.21 Therefore any multiple pressure ulcers of category/grade 2 or a grade 3 or 4, or un-stageable, un-gradeable, deep tissue injury identified within 72 hours of admission must be escalated and reported to the previous care provider as a clinical incidence. The 72 hour rule must be acknowledged and used as a guide, however it must be acknowledged a pressure ulcer can develop within a few hours.

1.22 Staff should also refer to:
- Their own organisation’s policies and procedures on pressure ulcers
- Other relevant local and national guidelines, protocols and policies e.g. NICE Guidance, incident reporting policies.

1.23 There will be a process for ensuring the validity of the safeguarding decision guide protocol in accurately reporting a safeguarding risk. A Safeguarding Quality Assurance Panel will meet once a month. The Terms of reference will be to review a percentage of the patients who have been assessed using the protocol. This will include referrals who were deemed a safeguarding risk and those who were not. This will show how effective the protocol is over a period of time. This Panel will also take a random selection from the Strategic Executive Information System (STEIS) to ascertain whether the safeguarding process has been followed.

2 Assessment Guidance
2.1 This is a multi-agency protocol which provides guidance for staff who are concerned that a pressure ulcer may have arisen as a result of poor practice or

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6 The term staff is used to refer to employees from all sectors.
neglect/abuse. The following provides guidance about when to refer as a safeguarding concern.

2.2 Assessment of the wound and completion of the decision guide must be completed by the first qualified member of staff who is a practicing registered nurse (RN) or GP with experience in pressure ulcer prevention and management. If the pressure ulcer is found within a non-clinical setting such as a residential care home or the person’s own home and is not currently being treated, a referral should be made by an appropriate health professional to review the wound e.g. General Practitioner or District Nurse as detailed in the organisation’s pressure ulcer prevention and management policy. A copy of the referral should be sent to Haringey Clinical Commissioning Group via the following email address: HARCCG.adultsafeguarding@nhs.net. Clinical settings are defined as: Hospitals; Mental Health Hospitals and Nursing Care Homes.

2.3 The practitioner who raises the concern should ensure that they speak with their line manager or an individual who is in a senior position e.g. Care Home Manager, Matron, GP, Social Worker or Care Homes Support Team Specialist Nurse. 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 report form in Appendix 3.

2.4 Where the patient has been transferred into the care of an organisation it may not be possible to complete the decision guide. Contact should be made with the transferring organisation to ascertain if a safeguarding alert has been raised or the decision guide has been completed; if neither then an alert should be raised.

2.5 The safeguarding decision guide should be completed immediately or 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 (Appendix 3).

2.6 Following this, a decision should be made whether to make a safeguarding referral to Social Services. For patients who score less than 15 on the decision making tool (Appendix 4) a safeguarding referral will not be required, however, patients who score 15 and above, this should be automatically referred. It should be noted that the score does not preclude clinical judgement. If the assessor feels there is an element of doubt then the patient should be referred to safeguarding even if the score is below 15.

2.7 The decision as to whether there should be a full investigation is made at the multi-agency Safeguarding Adults Strategy Meeting. The strategy meetings are convened in response to individual cases. A summary of the strategy discussion should be recorded and shared with all agencies involved.

2.8 The strategy meeting discussion will consider the Safeguarding referral and the 24 hour serious incident notification report and whether further information is required by the author. If it is decided to continue to the safeguarding process the strategy meeting will decide the type and time frame for completion of the investigation needed i.e. safeguarding investigation, serious incident investigation or a combination of both. The serious incident investigation will involve completion of the route, cause and analysis (RCA)
3 Initial history taking and safeguarding decision guide completion

3.1 Before considering the following questions please read Appendix 1 as this will give further guidance as to how to conduct the decision guide process.

3.2 The assessment must consider six key questions:

3.3 The six questions shown below together indicate a safeguarding decision guide score (Appendix 4). This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the potential of neglectful care/management resulting in the pressure ulceration. It is not a tool to risk assess for the development of pressure damage.

3.4 The threshold for referral is 15 or above. However this should not replace professional judgement.

   1. Has the patient’s skin deteriorated to either grade 3/4/ or un-stageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/visit
   
   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 at Life End), critical illness [http://www.epuap.org/wp-content/uploads/2012/07/SCALE-Final-Version-2009.pdf]
   
   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
   
   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 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

      Answer (a) if your patient has capacity to consent to every element of the care plan
      Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan

   5. Was the patient compliant with the care plan having received information regarding the risks of non-compliance?
   
   6. Was appropriate care undertaken in the patient’s best interests, following the best interests’ checklist in the Mental Capacity Act Code of Practice?
   
   7. NHS England (London Region) Principles of Best Practice in Safeguarding and Pressure Ulcer reporting-2014 (supported by documentation, e.g. capacity and best interest statements and record of care delivered)

3.5 Photographic evidence to support the report should be provided wherever possible. Consent for this should be sought as per local policy.

3.6 Body maps must be used to record skin damage and can be used as evidence if necessary at a later date. If two workers observed the skin damage they must both sign a body map (Appendix 2).

3.7 Documentation of the pressure ulcer must include site, size (centimetres) and category/grade. You must record your assessment on the Safeguarding Pressure Ulcer decision guide, see Appendix 4.

3.8 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.
Acknowledgements/References

These guidelines have been developed with reference to:

Haringey CCG Incident & Serious Incident Policy/Procedure (25th February 2016)
Newcastle Safeguarding Adults Board: Safeguarding Adults and Skin Damage Protocol: Deciding whether to refer to the Newcastle Safeguarding Adults Procedures (23rd April 2009)
Lewisham Primary Care Trust, London Borough of Lewisham, University Hospital Lewisham. Joint Protocol for Determining Neglect in the Development of a Pressure Ulcer (30th November 2007)
Lambeth and Southwark Safeguarding Adults Partnership Boards: Safeguarding Adults and Skin Damage Protocol: Deciding whether to refer to the Safeguarding Adults Procedures Acute Trusts Subgroup (September 2009)

Department of Health (2003) Essence of care service user focused benchmarks for clinical governance April 2003


“Mental Capacity Act 2005 Code of Practice”

Accessible online: http://guidance.nice.org.uk/CG29

European pressure ulcer advisory panel Pressure Ulcer Treatment Guidelines (1998)


http://www.epuap.org/gltreatment.html

Improving Care for people at the end of their life

Skin Changes at Life’s End: Final Consensus Statement

GUIDANCE FOR USE WITH THE SAFEGUARDING Decision Guide (Appendix 1)

Structure for assessment

History

- Include any factors associated with the person's behaviour that should be taken into consideration

Medical history

- Does the person have a long term condition which may impact on skin integrity; such as Rheumatoid Arthritis
- Is the person receiving palliative care?
- Does the person have any mental health problems or cognitive impairment which might impact on skin integrity? e.g. dementia / depression

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 person have reasonably required the monitoring of their skin integrity (where no monitoring has taken place prior to skin damage occurring)
- Did the person refuse monitoring? If so, did the person have the mental capacity to refuse such monitoring?
- Were any further measures taken to assist understanding e.g. patient information, leaflets given, escalation to clinical specialist, ward leads, team leader, and senior nurses?
- If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?

Expert advice on skin integrity

- Was appropriate assistance sought? E.g. professional advice from a District Nurse or Tissue Viability Specialist Nurse
- 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?
- If expert advice was provided did this inform the care plan?

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7 Family have no right to refuse monitoring
8 The person's consent to monitoring should always be sought, but if the person lacks the mental capacity to make a decision as to whether monitoring should take place, then the decision as to whether and, if so, how monitoring should take place should be made in the person’s best interests.
- 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 person has been assessed as lacking capacity to consent to the care plan, has a best interest decision been made and care delivered in their best interests?
- Did the care plan include provision of specialist equipment?
- Was the specialist equipment provided in 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 person have continence problems? If so are they being managed?
- Are skin hygiene needs being met? (including hair, nails and shaving)
- Has there been deterioration in physical appearance?
- Are oral health care needs being met?
- Does the person look emaciated or dehydrated?
- Is there evidence of intake monitoring (food and fluids)?
- Has patient lost weight recently? If so, is person's weight being monitored?
- Are they receiving sedation? If so is the frequency and level of sedation appropriate?
- Do they have pain? If so has it been assessed? Is it being managed appropriately?

**Other possible contributory factors**

- Has there been a recent change (or changes) in care setting?
- Is there a history of falls? If so has this caused skin damage? Has the person been on the floor for extended periods?
Appendix 2

Body map
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.

<table>
<thead>
<tr>
<th>Name of assessing nurse (PRINT)</th>
<th>Job Title</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of second assessor (PRINT)</td>
<td>Job Title</td>
<td>Signature</td>
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</table>

Patient Name: ................................................................. Patient No: .....................................................
## Appendix 3

### Adult Safeguarding referral regarding pressure ulceration

#### Details of individual with pressure ulcer(s)

<table>
<thead>
<tr>
<th>First name</th>
<th>Last name</th>
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<tr>
<th>D.O.B</th>
<th>NHS Number</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Borough of usual residence</th>
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#### Persons completing decision guide for safeguarding concern

<table>
<thead>
<tr>
<th>Department/ Base /Address</th>
<th>Organisation Name</th>
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<table>
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<th>Telephone Number</th>
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<table>
<thead>
<tr>
<th>Name of assessing nurse (PRINT)</th>
<th>Job Title</th>
<th>Signature</th>
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<tr>
<th>Name of second assessor (PRINT)</th>
<th>Job Title</th>
<th>Signature</th>
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<table>
<thead>
<tr>
<th>Date and Time assessors witnessed pressure ulceration</th>
<th>Date / time of completing documentation/referral</th>
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</thead>
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<td></td>
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#### Synopsis of concern regarding pressure ulceration and safeguarding

<table>
<thead>
<tr>
<th>State site and Category/ grade of all pressure ulcer(s)</th>
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</table>

<table>
<thead>
<tr>
<th>Decision guide Score</th>
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<table>
<thead>
<tr>
<th>Summary/ rational for decision re safeguarding referral</th>
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<tbody>
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<td></td>
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</tbody>
</table>

### Safeguarding referral

- [ ]

### Not for safeguarding referral

- [ ]
Reverse side of Appendix 3.

3.0 Initial history taking and safeguarding decision guide completion

3.3 The six questions shown below together indicate a safeguarding decision guide score (Appendix 4). This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the potential of neglectful care/management resulting in the pressure ulceration. It is not a tool to risk assess for the development of pressure damage.

3.4 The threshold for referral is 15 or above. However this should not replace professional judgement.

1. Has the patient’s skin deteriorated to either grade 3/4 or un-stageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/visit?
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 at Life End), critical illness http://www.epuap.org/wp-content/uploads/2012/07/SCALE-Final-Version-2009.pdf
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
4. Is there a concern that the Pressure Ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services?
5. Is the level of damage to skin inconsistent with the patient’s risk status for pressure ulcer development? e.g. low risk –Category/ grade 3 or 4 pressure ulcer
6. Answer (a) if your patient has capacity to consent to every element of the care plan
   Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan
   a) Was the patient compliant with the care plan having received information regarding the risks of non-compliance?
   b) Was appropriate care undertaken in the patient’s best interests, following the best interests’ checklist in the Mental Capacity Act Code of Practice?
## Appendix 4

<table>
<thead>
<tr>
<th>Q</th>
<th>Risk Category</th>
<th>Level of Concern</th>
<th>Score</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Has there been an unexpected deterioration in the patient’s skin integrity from the last opportunity to assess?</td>
<td>Progressive onset / deterioration of skin integrity</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sudden onset / deterioration of skin integrity</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>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 at Life End), critical illness</td>
<td>Change in condition contributing to skin damage</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No change in condition that could contribute to skin damage</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisation’s policy and guidance</td>
<td>Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs</td>
<td>0</td>
<td>State date of assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk tool used</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk assessment carried out and care plan in place documented but not reviewed as person’s needs have changed</td>
<td>5</td>
<td>What elements of care plan are in place</td>
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<tr>
<td></td>
<td></td>
<td>No or incomplete risk assessment and/or care plan carried out</td>
<td>15</td>
<td>What elements would have been expected to be in place but were not</td>
</tr>
<tr>
<td>4</td>
<td>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</td>
<td>No / Not applicable</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>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</td>
<td>Skin damage less severe than patient’s risk assessment suggests is proportional</td>
<td>0</td>
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<td></td>
<td>Skin damage more severe than patient’s risk assessment suggests is proportional</td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>Answer (a) if your patient has capacity to consent to every element of the care plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not all of the care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>Was the patient compliant with the care plan having received information regarding the risks of non-compliance?</td>
<td>Patient not compliant with care plan</td>
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<td></td>
<td>Patient compliant with some aspects of care plan but not all</td>
<td>3</td>
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<tr>
<td></td>
<td></td>
<td>Patient compliant with care plan or not given information to enable them to make an informed choice</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Was appropriate care undertaken in the patient’s best interests, following the best interests checklist in the Mental Capacity Act Code of Practice? (supported by documentation, e.g. capacity and best interest statements and record of care delivered)</td>
<td>Documentation of care being undertaken in patient’s best interests</td>
<td>0</td>
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<tr>
<td></td>
<td></td>
<td>No documentation of care being undertaken in patient’s best interests</td>
<td>10</td>
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**Patient Name:** ____________________________  **Patient No:** ____________________________

**Safeguarding Referral** ☐  **Not for Safeguarding Referral** ☐
Appendix 4
Adult Safeguarding Decision Guide for patients with pressure ulcers

GUIDANCE FOR USE WITH THE SAFEGUARDING Decision Guide (Appendix 1)
Structure for assessment

Reverse side of Appendix 4
GUIDANCE FOR USE WITH THE SAFEGUARDING Decision Guide (As in Appendix 1)

Structure for assessment

History
- Include any factors associated with the person’s behaviour that should be taken into consideration

Medical history
- Does the person have a long term condition which may impact on skin integrity; such as Rheumatoid Arthritis
- Is the person receiving palliative care?
- Does the person have any mental health problems or cognitive impairment which might impact on skin integrity? e.g. dementia / depression

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 person have reasonably required the monitoring of their skin integrity (where no monitoring has taken place prior to skin damage occurring)
- Did the person refuse monitoring? If so, did the person have the mental capacity to refuse such monitoring?
- Were any further measures taken to assist understanding e.g. patient information, leaflets given, escalation to clinical specialist, ward leads, team leader, and senior nurses?
- If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?

Expert advice on skin integrity
- Was appropriate assistance sought? E.g. professional advice from a District Nurse or Tissue Viability Specialist Nurse
- 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?
- 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?
- 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 person have continence problems? If so are they being managed?
- Are skin hygiene needs being met? (including hair, nails and shaving)
- Has there been deterioration in physical appearance?

9 Family have no right to refuse monitoring
10 The person’s consent to monitoring should always be sought, but if the person lacks the mental capacity to make a decision as to whether monitoring should take place, then the decision as to whether and, if so, how monitoring should take place should be made in the person’s best interests.
- Are oral health care needs being met?
- Does the person look emaciated or dehydrated?
- Is there evidence of intake monitoring (food and fluids)?
- Has patient lost weight recently? If so, is person's weight being monitored?
- Are they receiving sedation? If so is the frequency and level of sedation appropriate?
- Do they have pain? If so has it been assessed? Is it being managed appropriately?

**Other possible contributory factors**
- Has there been a recent change (or changes) in care setting?
- Is there a history of falls? If so has this caused skin damage? Has the person been on the floor for extended periods?