



Multi-Agency Safeguarding Guidance: Pressure Ulcer Pathway

Version	Date	Endorsed by:	Description
1.2	13/07/26	Berkshire Safeguarding Adults Policy and Procedures Subgroup	FINAL
1.3	10/08/26	Berkshire Safeguarding Adults Policy and Procedures Subgroup	Links added

Contents

1. Aim of the Pathway and Introduction 3

2. Reporting of Pressure Ulcers 3

3. How to Use the Pressure Ulcer Safeguarding Pathway..... 4

4. Completing the Adult Safeguarding Decision Guide, When to Raise a Safeguarding
Concern with regards to Pressure Ulcers Appendix 5.2 5

5. Considerations when completing Adult Safeguarding Decision Guide, When to Raise a
Safeguarding Concern in Relation to Pressure Ulcers - Appendix 5.2..... 6

6. Management of the Safeguarding Concern..... 8

7. Supporting Appendices 8

8. Acknowledgement / References..... 8

1. Aim of the Pathway and Introduction

This is a multi-agency pathway which aims to support decisions about appropriate responses to pressure ulcer care. It provides guidance for staff in all sectors who are concerned that a pressure ulcer may have arisen as a result of poor practice, abuse, self-neglect, neglect or acts of omission and therefore must decide whether to raise a safeguarding concern to the Local Authority. A flow diagram outlining the key elements of the pathway can be found in **Appendix 5.1**.

From a governance perspective, each organisation will be responsible for ensuring that the pathway is used appropriately.

Neglect and acts of omission are a form of abuse which involves the deliberate withholding or unintentional failure to provide appropriate and adequate care and support. In relation to pressure care, the neglect or act of omission could have resulted in or is highly likely to result in significant pressure ulcers which were preventable and identify learning.

Pressure ulcers have a number of causes, some relating to the individual person, such as refusal of care and/or equipment, 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 pressure ulcers can be prevented and therefore the risk factors in each case should be reviewed on an individual basis before raising a safeguarding concern is considered.

Staff have a duty of care to report all cases of actual or suspected abuse and/or neglect through the safeguarding process.

2. Reporting of Pressure Ulcers

Cases of single category 1 or 2 pressure ulcers must be considered as requiring early intervention to prevent further damage. If there are concerns regarding poor practice, an appropriate action must be considered to reduce future risks, i.e. raising a clinical incident report or looking at further training in pressure-source management.

The person is to be referred to safeguarding if:

- Significant pressure damage i.e. category 3 or 4, unstageable ulceration, deep tissue injury or multiple category 2, and
 - There are reasonable grounds to suspect it was preventable, or
 - Inadequate measures were taken to prevent development of pressure ulcers, or
 - Inadequate evidence to demonstrate the above, or
 - There are concerns about self-neglect.

Significant skin damage is indicated by two or more pressure ulcers of category 2, or 1 or more category 3 or 4, DTI and unstageable. It is essential to use a classification system to determine the category of a pressure ulcer. Definitions of pressure ulcer categories can be found in the National Wound Care Strategy Programme (NWCSP) [National Wound Care Strategy Programme - The Health Innovation Network](#) and [European Pressure Ulcer Advisory Panel \(EPUAP\)](#) in November 2019. For the DOH guidance please follow the link: [Safeguarding adults' protocol: pressure ulcers and raising a safeguarding concern - GOV.UK](#)

The pressure ulcer safeguarding pathway is to be applied to significant pressure ulcers reported by anyone including carers, relatives and the person.

Any category 2 and above pressure ulcer must be reported as a clinical incident according to local clinical governance procedures.

There are requirements for adult health and social care providers to report pressure ulcers that are assessed at category 3, 4, unstageable or deep tissue injury, or as a vulnerable pressure area (VPA) that have developed in their service to the appropriate governing body. The ICB for NHS providers and the CQC for registered services under **Regulation 18: Notification of other incidents**.

Where concerns are raised regarding pressure ulcers organisations are to follow their own internal procedures such as the completion of a clinical incident form as well as raising a safeguarding concern when deemed required by the pathway.

Any category 3,4, deep tissue or unstageable pressure ulcer identified at the first skin assessment of admission or start of service delivery must be escalated and reported to the previous care provider as a clinical incident if the previous care provider was delivering support that involved pressure care management.

It is best practice to discuss any concerns identified and the steps that are being taken with the person if this is appropriate.

In addition to this pathway, you should also refer to:

- Your own organisation's policies and procedures on pressure ulcers.
- Other relevant local and national guidelines, protocols and policies e.g. [Pressure ulcers | Health topics A to Z | CKS | NICE](#) Incident reporting policies.

3. How to Use the Pressure Ulcer Safeguarding Pathway

The following provides guidance on when and how to use the pathway (**Appendix 5.1**) to support decision making on whether or not a safeguarding concern should be raised.

The outcome of the decision must be documented on the report form (**Appendix 5.2**). If further advice/support is needed with regards to making the decision to refer to safeguarding, the Safeguarding Adults Lead within the Local Authority or provider organisation should be contacted.

Completion of the pathway must be completed by the first qualified member of staff with experience in pressure care. This does not have to be a Registered Nurse please refer to your own organisation's policies and procedures to identify a qualified member of staff with training and experience dealing with tissue-viability clinical care. Whilst national guidance does state a qualified/ registered nurse, this is guidance and organisations may adapt and use trained and experienced members of staff.

The pathway should be completed immediately or within 24 hours following the identification of the pressure ulcer concern. In exceptional circumstances the timescale may be extended but the reasons for the extension must be documented.

Where the individual has been transferred into the care of an organisation with significant pressure damage the decision guide **Appendix 5.2** is still to be completed. As far as is reasonably possible, contact should be made with the transferring organisation to ascertain if the decision guide has been completed and if not, it should be completed jointly, or an agreement made about which agency should complete it.

On completion of the decision guide, a decision is to be made whether to raise a safeguarding concern. The concern should be raised immediately after the decision including a copy of the completed decision guide (**Appendix 5.3**).

4. Completing the Adult Safeguarding Decision Guide, When to Raise a Safeguarding Concern with regards to Pressure Ulcers **Appendix 5.2**

The decision guide consists of six key questions which together provide a decision guide score, this is to be scored and recorded using **Appendix 5.2**.

The threshold for a safeguarding concern is 15 or above. However, this must not replace professional judgement. This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the potential neglectful care/management resulting in the pressure ulcer(s).

The decision guide is not a tool to risk assess for the development of pressure damage.

Body maps must be used to record pressure ulcers (**Appendix 5.3**) and can be used as evidence, if necessary, at a later date (*Electronic records are used in some acute setting instead of body maps*). If two workers observed the pressure ulcers, they must both sign the body map. There may be occasions when photographic evidence is appropriate,

Photographic evidence can only be provided when there is access to suitable photographic equipment (for example not a worker's personal mobile phone). Consent for photographic evidence needs to be sought which is in line with organisation's policies and procedures.

When the decision guide has been completed it should be stored in the person's notes, regardless of the outcome.

5. Considerations when completing Adult Safeguarding Decision Guide, When to Raise a Safeguarding Concern in Relation to Pressure Ulcers - Appendix 5.2

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?
- Has the patient's Mental Capacity to make the decision been assessed and documented in the care records?
- Were any further measures taken to assist understanding e.g. person information, leaflets given, escalation to clinical specialist, ward leads, team leaders, 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 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?
- 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 a 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 person 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?
- Has the appropriate equipment been provided to prevent deterioration of skin?

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?

If you are unsure if a safeguarding referral is needed, please contact your Local Authority Safeguarding team to discuss the case and they will advise you.

6. Management of the Safeguarding Concern

On receipt of the safeguarding concern the Safeguarding Adults Team (SAT) will consider thresholds for a S42 enquiry and open the enquiry if thresholds are met. A record of the safeguarding concern will be made regardless of whether the S42 enquiry threshold has been met.

The SAT will work with the organisation involved to seek assurances that lessons have been learnt, if assurance cannot be provided the SAT will consider if there is a systemic issue with the organisation. The concerns may be addressed through the following: S42 enquiries, care management pathways, care quality frameworks or risk management processes.

In cases open to any NHS services the development of a category (multiple 2, 3, 4 unstageable or deep tissue injury will initiate the patient Safety Incident Response Framework (PSIRF) process in line with local policies e.g. pressure ulcer or risk management policies. Safeguarding Adults Teams can request copies of any outcome of an investigation for its enquiries.

If in any doubt as to whether to raise a safeguarding concern, please contact the relevant LA to discuss.

7. Supporting Appendices

- **Appendix 5.1 - Decision flowchart** – When to raise a safeguarding concern in regard to pressure ulcers
- **Appendix 5.2: Adult Safeguarding Decision Guide** - when to raise a safeguarding concern in regard to pressure ulcers
- **Appendix 5.3: Body Map** – to document pressure ulcers
- **Appendix 5.4 Pressure Ulcer examples** – pictures of pressure ulcers to support professionals.

8. Acknowledgement / References

This pathway has been developed with reference to:

<https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and-measurement-framework/> (accessed March 2019)

Newcastle Safeguarding Adults Board: Safeguarding Adults and Skin Damage Protocol: Deciding whether to refer to the Newcastle Safeguarding Adults Procedures (23 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 (30 November 2007)

Lewisham Primary Care Trust, London Borough of Lewisham, University Hospital Lewisham. Joint Protocol for Determining Neglect in the Development of a Pressure Ulcer (30 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

National Institute for Health and Clinical Excellence (2005) Guidance for the prevention and treatment of pressure ulcers September 2005

Mental Capacity Act 2005 Code of Practice” Accessible online:

<http://guidance.nice.org.uk/CG29>

European pressure ulcer advisory panel Pressure Ulcer Treatment Guidelines 2014 **<https://www.epuap.org/pu-guidelines/>**