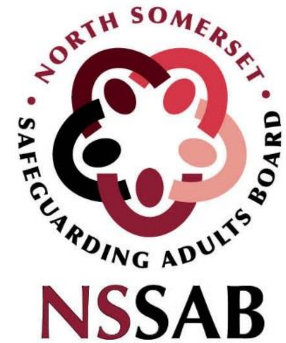
North Somerset Safeguarding Adult Board

Pressure Injury Protocol

This is an approved North Somerset Safeguarding Adult Board document and should not be edited in any way



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1. Introduction

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 safeguarding procedures when concerns have been raised that a pressure injury (of any grade) 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 injury was caused as a result of neglect, or poor care practice and whether an enquiry under safeguarding adults procedures should take place. It will provide a focus on thresholds for raising a safeguarding concern and subsequent s.42(1) decision making.

This guidance applies to all health and social care staff in North Somerset who work with adults at risk who either develop a pressure injury or are at risk of developing a pressure injury. It is important that this protocol dovetails into and is embedded within each organisation's own pressure injury prevention and management policies and guidance. This guidance should also be read in conjunction with the North Somerset Safeguarding Adults Board Multi-Agency Adult Safeguarding Procedures (2019).

2. Pressure injury definition and grading

The NHS definition of a pressure injury is *"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".* (NHS Improvement (2018). Pressure ulcers: revised definition and measurement)

NICE define those at risk of pressure injuries as follows;

"All patients [or those people with care needs] are potentially at risk of developing a pressure ulcer. However, pressure ulcers 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." NICE 2014

New terminology and grading systems are used in the assessment and definition of pressure injuries. These can be found at **Appendix 1**.

Changes include;

- The word 'grade' to replace 'category'
- Deep tissue injuries (The injury will do one of two things, resolve with no tissue loss or deteriorate showing the true extent of tissue damage)
- Move away from using the term 'kennedy ulcer', adopting the description of skin failure at end of life using assessment and grading as per usual definitions. In some cases, pressure injuries are recognised as unavoidable.
- Moisture lesions are (areas of moisture associated skin damage, often very painful, resulting from prolonged contact with urine, faeces and or perspiration and therefore may also indicate care concerns)
- Unstageable injuries (where the wound is obscured and the depth cannot be assessed) will often become grade 3 or 4 injuries.

- Medical device related injuries may be related to use of catheters or oxygen pipes for example.

Not all skin or tissue damage is a pressure injury. It is recognised that 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.

3. Neglect or poor care practice relating to pressure ulcers

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

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

Pressure injuries can occur in any individual but are more likely in high risk groups. To consider whether the pressure injury has developed as a result of neglect or poor practice from care providers requires an understanding if the pressure injury was avoidable.

NHS England (2016) has defined unavoidable and avoidable pressure injuries as follows:

Unavoidable Pressure Ulcer:

- *A pressure injury that has developed despite the care provider evaluating the patient's clinical condition and pressure injury 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 Pressure Ulcer:

- *The person providing care did not:*
- *Evaluate the patient's clinical condition and identify pressure injury 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 injury (or other skin/tissue damage) is believed to have been caused by neglect, or organisational abuse, it should be raised as a safeguarding adults concern.

Regardless of whether or not concerns exist about the persons care or treatment, registered social care providers are required to inform CQC, via a regulation 18 notification, of all grade 3 or 4 pressure injuries which has developed after the person started to use their service (CQC 2015). Care Quality Commission (Registration) Regulations 2009: Regulation 18

If a registered provider suspects that a pressure injury has developed as a result of neglect outside of their service, they are required to notify the CQC. Care Quality Commission (Registration) Regulations 2009 Regulation 18(2)

NHS commissioned organisations are required to investigate grade 3 and 4 pressure injuries 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, in the context of pressure injury 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 injury'.

4. Neglect and organisational abuse

In the context of adult safeguarding and pressure injuries, organisational abuse refers to *the mistreatment of multiple people brought about by poor or inadequate care or support, or systematic poor practice and neglect*

5. Duty of Candour

The Health & Social Care Act 2008 (Regulated Activities), Regulations 2014: Regulation 20 places a duty on health and social care providers are required to be 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.

Health and social care providers are therefore directed to comply with their organisational polices to ensure that their Duty of Candour is met.

6. Mental Capacity Act and pressure injury prevention

An adult with capacity has the right to refuse treatment.

Agencies should work with individuals to manage risk associated with an adult's decision.

In such circumstances a risk assessment must also be completed (in line with the organisation's 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 following the North Somerset Safeguarding Adults Self-Neglect Protocol.

However, where the person, or patient, lacks mental capacity to consent to or comply with pressure ulcer preventative measures care providers will need to act in the best interests of the person to develop and implement 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 consider an individual's ability to act on advice and information.

7. Deciding when to raise a safeguarding adults concern

All pressure injuries must be considered as having the potential to indicate neglect.

When the concern relates to professional care delivery;

If an appropriately skilled professional is involved and there are concerns about professional care delivery, the appropriately skilled person should assess the care given against the matrix in appendix 2 (DH 2018).

If in the professional's judgement there are concerns regarding the care and treatment of an individual *or* if the safeguarding matrix scores 15 or above, a safeguarding adults concern must be raised through Care Connect.

If a decision is made that a safeguarding concern will not be raised, then health and care professionals must still follow their own agencies policies and procedures and ensure relevant statutory notifications are made.

Safeguarding is everybody's business: Therefore if there is no relevant professional involved and concerns exist regarding the development of any pressure injury, a safeguarding concern should be raised. Consideration should also be given to invoking a response under Self-Neglect procedures

When the concern relates to informal carers

A person in receipt of informal care and support from friends and family for example may also develop pressure injuries.

Early identification of a carer can prevent a breakdown in the health of the cared-for, in the carer's own welfare, and in their ability to provide appropriate care. There is a duty for all professionals to pro-actively identify carers and to ensure they are provided with the information and support they need to fulfil the caring role safely. The significance of this cannot be over-emphasised.

'Where unintentional neglect may be due to an unpaid carer struggling to provide care an appropriate response would be to revise the package of care and ensure that the carer has the support and equipment to care safely. In these circumstances it can be highly distressing to talk to carers about abuse and neglect, particularly where they have been dedicated in providing care but have not been given advice and support to prevent pressure ulcers.' (DH: 2018)

All carers are eligible for a Carers Assessment by Adult Social Care under the Care Act. This looks at the carer's needs for support which arises as a result of the caring role. It includes consideration of whether the carer is 'willing and able' to provide care.

When a carer is identified by a professional, they should be offered a Carers Assessment. A referral is made by contacting Care Connect to request this.

Appendix 3 provides a tool for supporting safeguarding decision making in pressure injury concerns involving informal carers.

8. S.42(1) Decision making

When a safeguarding concern is raised North Somerset Council must consider if there is *reasonable cause to suspect* that an adult;

- has care & support needs
- is experiencing, or is at risk of abuse or neglect *and*
- can't protect themselves *as a result of their needs.*

And

- establish the views of the adult on the nature, level and type of risk and support they need to mitigate the risk

For the purposes of this protocol, North Somerset Council will consider a person to be "experiencing or at risk of the experience of neglect" if they have been assessed as scoring 15 or above according to the department of health matrix in appendix 2 below.

However, not all safeguarding concerns regarding pressure injuries will use the appendix 2 matrix. In such cases, the local authority will undertake proportionate information gathering to decide whether there is reasonable cause to suspect that an adult has experienced or is at risk of the experience of abuse or neglect.

Examples of the type of information that could be relevant are;

- Source of risk (previous concerns)
- Adult at risk (previous concerns)
- Period of time the injury has taken to develop
- Timeliness of actions taken
- Assessment of pressure needs for the adult at risk
- Pressure care planning for the adult at risk
- Pressure care and equipment provision for the adult at risk
- Relevant Health condition for the adult at risk
- Grade of injury

The following will also influence the decision;

- Source of contact (has a service self-disclosed)
- Views of the adult at risk or their representative
- Person in a position of trust responsibilities
- Risk to others

9. S.42(2) Safeguarding enquiries into pressure injuries

The Care Act (2014) 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 injuries 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 it was unavoidable or avoidable and consider what response is required. This may include taking actions to improve 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).

Step one:

Make safeguarding personal

Consult with the adult at risk or their representative and establish their views, wishes and desired outcomes.

Step two:

Establish the facts

Consult with appropriately skilled staff to establish the following,

- What is the current level of risk and is appropriate support now in place? Was there an indication that pressure needs should be assessed?
- Was the deterioration predictable?
- Was the need for pressure care adequately assessed?
- Was timely specialist advice sought if required?
- Was the care plan revised appropriately?
- Was the equipment provided in a timely manner?
- Was the equipment used appropriately?
- Was care provided according to the care plan?
- What indications were present that skin condition was deteriorating (changes in the presentation of the skin (e.g. persistent change in colour, temperature of skin etc.)
- If the treatment of the skin condition was then refused by the adult at risk was it reasonable for specialist advice to be sought?
- If monitoring was then refused by the adult at risk/family was it reasonable for advice to be sought? (The family has no right to refuse monitoring on behalf of the person without capacity)
- Did the organisation follow its own procedures (e.g SSKIN Bundle/Standard operating procedures)

Step three:

Draw conclusions by assessing in consultation with appropriately skilled professionals whether there is evidence of neglect which has resulted in this pressure injury developing

Make recommendations according to the enquiry findings.

Step four:

Consult with the adult at risk or their representative and consider progress against their desired outcomes and their need for redress and resolution

Step five:

Agree how recommendations will be followed up

Step six:

Share outcomes with relevant organisations

10. References

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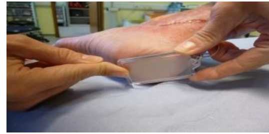
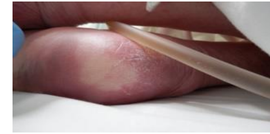
Appendix 1

Pressure Injury Categorisation

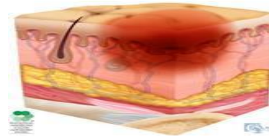
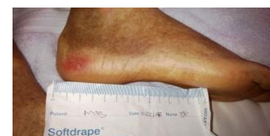
NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

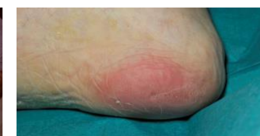
Pressure Injury Categorisation Tool

Blanching erythema: Healthy skin may develop transient redness when subjected to pressure – for example if the legs are crossed – to test if damage has occurred light figure pressure should be applied to see if the skin blanches (goes white). In darker skin tones redness may present as a darker area that is grey or purplish. This is NOT a pressure injury

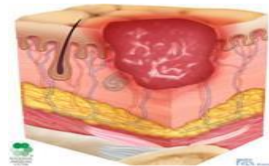
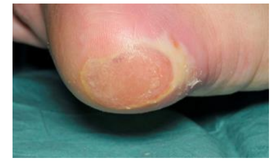
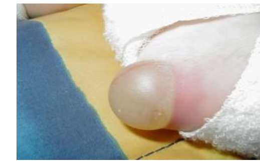
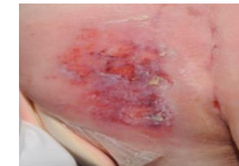
Grade 1: Non-blanchable Erythema
Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible redness its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. Tissue is already damaged and needs immediate pressure relief.

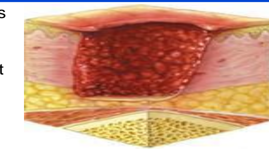


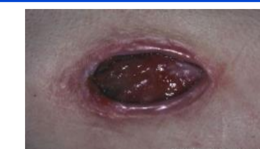
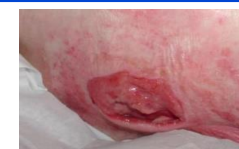
Grade 2: Partial Thickness Skin Loss
Partial thickness loss of dermis presenting as a shallow open injury with a red pink wound bed, without slough.
May also present as an intact or open/ruptured serum-filled blister.
Presents as a shiny or dry shallow injury without slough or bruising.* This Grade should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

*Bruising can indicate suspected deep tissue injury.

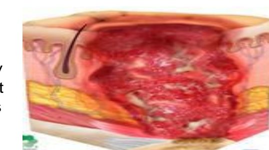





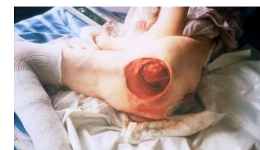
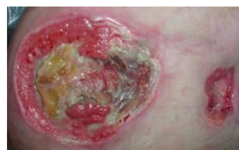
Grade 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. May include undermining and tunnelling. The depth of a Grade 3 pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Grade 3 injuries can be shallow. In contrast, areas of significant adiposity can develop extremely deep Grade 3 pressure injuries. Bone & tendon is not visible or directly palpable.



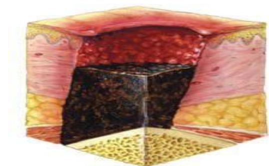
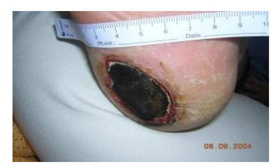



Grade 4 Full Thickness Tissue Loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Grade 4 pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these injuries can be shallow. Grade 4 injuries can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.



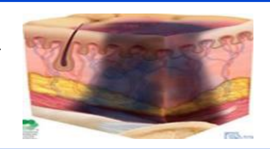
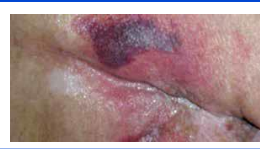
Unstageable: Depth Unknown
Full thickness tissue loss in which the base of the injury is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Grade, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

The necrotic cap on this heel has softened and started to separate

Although still firmly attached there is a ring of demarcation where this eschar has been rehydrated

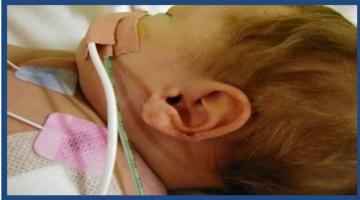
Deep Tissue Injury: Depth Unknown
Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Medical Device related Pressure Injuries

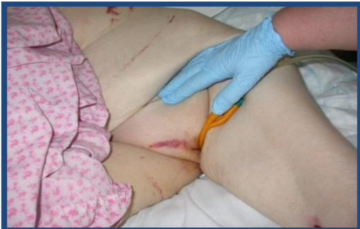
“Pressure Injuries that result from the use of devices designed and applied for diagnostic or therapeutic purposes.

Whilst some DRPI may also be allocated a Grade of damage others may not as they are on parts of the anatomy that does not have the same structures as the skin – for example the mucosal membrane. Where possible a device related injury should be categorised and the presence of a device noted by the addition of a (d) after the Grade.

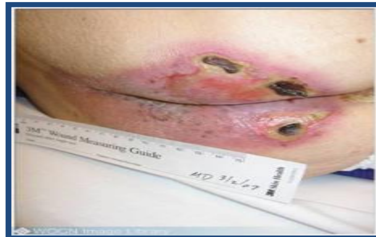


This infant has Grade 1 damage to the cheeks and a small unstageable injury on the ear

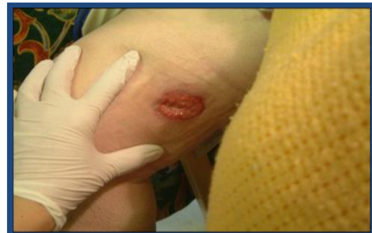
This damage was caused by oxygen tubing



The damage caused by this urinary catheter could be categorised as a DTI (d)



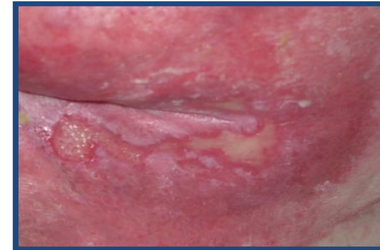
This damage was cased by a bedpan

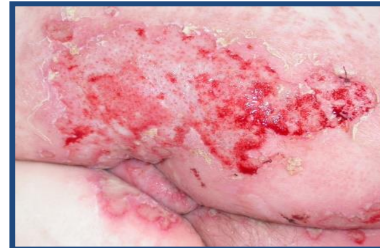


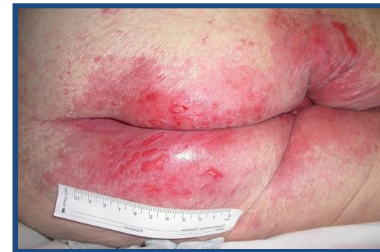
Although difficult to identify, this PI was caused by the leather ring at the top of a old fashioned calliper

Moisture Associated Skin Damage due to incontinence

This can occur due to the presence of urine and faecal moisture on the skin.







Appendix 2 **Pathway 1 Concern regarding professional care delivery**

Q	Risk Category	Level of Concern	Score	Evidence

2	Has there been a recent change, i.e. within days or hours, in their / clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anaemia, end of life care, critical illness	Change in condition contributing to skin damage	0	
		No change in condition that could contribute to skin damage	5	

3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	0	State date of assessment Risk tool used Score / Risk level
		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	What elements of care plan are in place
		No or incomplete risk assessment and/or care plan carried out	15	What elements would have been expected to be in place but were not

5	Is the level of damage to skin inconsistent with the patient’s risk status for pressure ulcer development? e.g. low risk–Category/ grade 3 or 4 pressure ulcer	Skin damage less severe than patient’s risk assessment suggests is proportional	0	
		Skin damage more severe than patient’s risk assessment suggests is proportional	10	

6	Answer (A) if your patient has capacity to consent to every element of the care plan. Answer (B) if your patient has been 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?	Patient has not followed care plan and local non-concordance policies have been followed.	0	
		Patient followed some aspects of care plan but not all	3	
		Patient followed care plan or not given information to enable them to make an informed choice.	5	
B	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)	Documentation of care being undertaken in patient's best interests	0	
		No documentation of care being undertaken in patient's best interests	10	
		Total Score		

If the score is 15 or over, discuss with the local authority (safeguarding) as determined by local procedures and reflecting the urgency of the situation. When the decision guide 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.

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

Appendix 3 **Pressure Ulcers Pathway 2: Concerns about informal carers**

North Somerset Safeguarding Adults Board believes that;

Where unintentional neglect may be due to an unpaid carer struggling to provide care an appropriate response would be to revise the package of care and ensure that the carer has the support and equipment to care safely. In these circumstances it can be highly distressing to talk to carers about abuse and neglect, particularly where they have been dedicated in providing care but have not been given advice and support to prevent pressure ulcers.

To determine if the identification of a pressure injury on an individual with NO professional support should result in a safeguarding referral the following should be considered.

	Possibly NOT Safeguarding at this stage	Consider raising a safeguarding adults concern	Raise a Safeguarding Adults Concern
What is the severity (grade) of the pressure injury?	grade 2 pressure injury or below – care plan required	Several grade 2 pressure injuries/ grade 3 to 4 pressure injuries- consider question 2	Grade 4 OR other issues of significant concern
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.	carer not 'willing and able' to provide/ sustain the care required but will accept support	Assessed as NOT having capacity and treatment NOT provided Carer not 'willing and able' and unwilling to accept support.
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 despite advice given previously by health professionals If advice has not been given by health professionals, refer back to Pathway 1 above.
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 but some aspects may have been declined e.g. certain equipment.	NO cooperation and refusal to implement care plan and or purposeful neglect.
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 tend.