South West London Integrated Care System

South-West London Integrated Care System Safeguarding Adult Protocols on Falls, Medication Errors, and Pressure Ulcers

Version 3, January 2025
Update due: January 2027

Foreward

I am delighted to present the revised South West London Integrated Care System Safeguarding Adult Protocols on Falls, Medication Errors, and Pressure Ulcers.

The prevention of falls, medication errors and pressure ulcers are a marker of quality of care, and whilst not all incidents can be prevented, comprehensive protocols have an impact on patient safety. These protocols have been reviewed and agreed as a system with representatives from health and social care across South West London. The protocols reflect current national guidance and legislation and promote a proactive and collaborative approach which will reduce harm and secure efficiencies to the wider health and social care system.

I hope that these protocols will provide professionals with the opportunity and resources to improve the lives of people living in or receiving care and treatment in South West London.

Elaine Clancy
Chief Nursing Officer, NHS South West London

Acknowledgements

These guidelines were developed by the South West London (SWL) Integrated Care System and acknowledgments go to the following organisations who made contributions:

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- Kingston Adult Social Care
- Kingston Hospital NHS Foundation Trust
- Merton Adult Social Care
- Richmond Adult Social Care
- South West London Integrated Care Board
- St Georges NHS Foundation Trust
- Sutton Adult Social Care
- Sutton Health and Care
- Wandsworth Adult Social Care
- Your Healthcare

South West London Integrated Care System

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Protocol on Safeguarding Adults Enquiries for Medication Errors

1. Introduction

1.1. The Care Act 2014 defines Safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm, or neglect of adults.

1.2. The Safeguarding duties apply to adults who have needs for care or support (whether or not the local authority 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. [DOH Care and Support Statutory Guidance, updated 27 September 2024].

1.3. All notifiable incidents should be reported to the CQC in line with the requirements of the Health and Social Care Act 2008 Regulations 2014. The law requires these notifications to be submitted within certain timescales – further guidance is available on what should be reported, how and in what timescales via the CQC guidance on Statutory Notifications. See "Notification: guidance for providers" https://www.cqc.org.uk/guidance- regulation/providers/registration/guidance.

1.4. This protocol provides guidance for health and social care staff to identify when a medication error should also trigger a safeguarding alert. The threshold for raising safeguarding alerts is purposefully low, all alerts will then be triaged in line with the safeguarding process and a proportionate response will be decided in line with the available evidence and the Making Safeguarding Personal approach.

2. Purpose of the protocol

2.1. This multi-agency protocol has been developed to assist in decision making as to whether to report a medication error as a safeguarding concern. It provides good practice guidance to support all agencies in making a referral decision. It is not a substitute for organisation's requirements to provide safe and effective care and to have an appropriate policy and procedures to guide staff.

2.2. Every organisation is responsible for ensuring that the protocol is used appropriately and monitor and review its use. This would include reviewing decisions to raise or not raise concerns within internal governance processes and managing medication errors within the organisations policy.

3. Defining medication errors

3.1. Medication Errors can be defined as any Patient Safety Incidents (PSI) where there has been an error in the process of prescribing, preparing, dispensing, and administering, monitoring, or providing access to medicines, as defined by NHS Resolution and the Care Quality Commission (CQC). Medication Errors can occur at many steps in patient care, from ordering the medication to the time when the patient was administered the drug and are not the same as adverse drug reactions. Medicine errors can result in severe harm, disability, and death.

3.2. Medicine errors can occur when there are deficient medication systems or when human factors affect processes. This can include a lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor instruction, poor communication fatigue, environmental conditions, and staffing levels.

3.3. There are several national and professional guidelines relating to medicines management, these include but not exhaustively; The National Institute for Care Excellence (NICE) - "Managing medicines

in care homes" on 14 March 2014; and "Managing medicines for adults receiving social care in the community" in March 2017; as well as the Nursing and Midwifery Council; The Code – Professional standards of practice and behaviour for nurses and midwives.

4. Statutory responsibilities

4.1. All people working with adults must work to protect service users against the risks associated with the unsafe use and management of medicines, especially registered staff whose role it is to prescribe or administer medications as per the Care Act 2014 and Statutory Guidance. By working to protect vulnerable adults this means through appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration, and disposal of medicines used.

4.2. All medication errors including near misses, regardless of whether there are potential safeguarding concerns, should be recorded on organisational systems as soon as possible after the incident. It is good practice that this record details the error itself and the impact of the error, any immediate action taken and record the date, time and names of staff and service users involved. All staff should refer to their organisational Medicines Management Policy and Procedure around local processes and procedures.

4.3. As a part of internal organisational processes, medication errors should be reviewed and if appropriate conducting an After-Action Review in line with the Patient Safety Incident Response Framework (PSIRF) to ensure lessons are learnt and the risk of the error being repeated is reduced. It is also important to review the error in the context of previously recorded errors as a series of similar incidents may meet the criteria for referral into safeguarding.

4.4. Where there are concerns that the medication error might be a safeguarding concern (as per below), all staff working with adults at risk have a duty to seek advice and support and raise a concern.

5. Managing medication errors in the context of adult safeguarding

5.1. It is important to note that not all medication errors should be regarded as needing a safeguarding enquiry and some scenarios will need escalation and further discussion to agree if it meets the safeguarding threshold. However, the pathway for safeguarding may be met when there is concern about possible abuse or neglect, involving the suspected experience or risk of actual harm.

5.2. The following are examples of high-risk situations which should be raised as a Safeguarding Adults Concern (please note this is not an exhaustive list):

- Recurrent missed medication or administration errors that affect one or more adult and/or result in harm.
- Maladministration of medicines (e.g. sedation)
- Covert administration without proper medical supervision or outside the Mental Capacity Act, with a detrimental impact
- Pattern of recurring administration errors
- Incident of maladministration that results in ill-health or death.
- Falsification of records or coercive/ intimidating behaviour to prevent reporting
- A medication error requiring medical intervention e.g. emergency intervention required, such as LAS being called.

5.3. Where there has been some harm or risk of harm (i.e. medium risk incident), these should be escalated and discussed locally to determine if it meets the safeguarding threshold and considered in association with wider public risks.

5.4. Staff should be aware of their own organisation's policies and procedures on medication management

and other relevant local and national guidelines, protocols, and policies e.g. NICE guidance, NMC, incident reporting policies, which will include Trust Medicines Management Policies and Procedures.

5.5. It must be acknowledged that there may be incidents where decision-making is not straightforward and professional judgement is required which must take account of the MCA.

5.6. *Please See Appendix 1 – Safeguarding and Medication Errors Threshold Guidance* which provides further examples of concerns and when a safeguarding concern should be raised or when local monitoring and action is proportionate. Where there is a query as to whether the incident meets the threshold for adult safeguarding, local escalation and discussion should be held. If in doubt a safeguarding referral should always be made.

5.7. Where a safeguarding concern relating to a medication error is progressed to a safeguarding enquiry, it is important that a multi-agency approach is taken and there is involvement relevant healthcare professional (e.g. hospital pharmacist, ICB care home pharmacist, or GP).

6. Delegated enquiries

6.1. The Care Act 2014 provides local authorities with the opportunity to "cause others to undertake enquiries", which is referred to as "delegating responsibility" for leading safeguarding enquires where an incident occurs within their own organisation.

6.2. In the case of medication errors, in many instances health care professionals within an organisation responsible for that individual's treatment will be best placed to lead these enquiries and so delegation should always be considered in the management of medication errors.

6.3. A Safeguarding Adults (s42) Enquiry Planning Discussion, coordinated by the local authority, is the appropriate forum to decide on the scope of the enquiry to be addressed by relevant agencies.

6.4. Where the medication error meets the safeguarding threshold (see appendix 1), a safeguarding referral must be made to the local authority. You will be invited to a planning meeting where a decision may be made to delegate responsibility. A summary of the discussion will be recorded by the local authority and shared with the agencies involved in the discussion.

6.5. If the enquiry is delegated to the reporting partner, the work of the enquiry will involve either a concise overview or a comprehensive After-Action Review (under PSIRF) or Root Cause Analysis/Serious Incident investigation. This should be completed by an appropriately skilled and trained person such as registered nurse, pharmacist, or nursing home manager in line with the providers Medicines Management Policies. It is important that where there are notifiable safeguarding concerns these must be reported to the CQC (or another appropriate regulator).

6.6. The principles of Making Safeguarding Personal should be adhered to and therefore there should be a discussion with the patient (and/or their representative or advocate) in terms of what they want to happen in terms of undertaking an enquiry. It should be clearly agreed who will have this discussion. In determining who it is most appropriate to hold the discussion with the principles of the Mental Capacity Act should be considered.

6.7. The outcome of the After-Action Review/RCA/SI findings should be shared with the local authority. This will include information on (as an example):

- Expected outcome – what should have happened.
- Event outcome – what did happen.
- Analysis – what was the difference in the expectation and event.
- Any of the contributory factors to note
- Safety actions – any immediate actions taken.
- Areas for improvement – wider themes/areas for improvement

6.8. The local authority officer will record the information from the delegated enquiry for reporting to the Safeguarding Adults Partnership board.

6.9. If a full enquiry is to be undertaken the local authority will lead on the enquiry following local procedures.

7. Persons in Positions of Trust (PiPOT)

7.1. People in Positions of Trust (PiPOT) are those who work with adults who have care and support needs. When allegations are made against a person in positions of trust, they must be taken seriously to protect adults and maintain safe working practices. Local procedures relating to Persons in Positions of Trust should be referred to when there is an allegation made against a person working with an adult at risk.

8. Review

8.1. This protocol will be reviewed bi-annually.

9. References

Care Act 2014 c. 23. Available at: Care Act 2014 (legislation.gov.uk). [Last accessed 4th October 2024].

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Appendix 1 – Safeguarding Adults and Medication Error Threshold Guidance

Adapted from the London Borough of Merton – Adult Safeguarding Threshold Practice Guidance

Type of abuse: Mismanagement, misadministration, and/or misuse of medication

(Could constitute Neglect and Acts of Omission / Physical Abuse / Organisational Abuse)

No Reporting	**Requires Consultation**	**Safeguarding Adults Concern to be Raised (To Be Reported)**
Low risk No impact	Medium risk Some harm or risk of harm	High risk Significant harm or risk of harm
Lower-level concern where threshold of further enquiries under safeguarding are unlikely to be met. However, agencies should keep a written internal record of what happened and what action was taken, following your own internal process. Where there are a number of low- level concerns consideration should be given as to whether the threshold is met for a safeguarding enquiry due to increased risk	Incidents at this level could be escalated locally (i.e. discussion with organisations safeguarding lead / their manager). After the conversation, they may request you formally report the concern as a safeguarding	Incidents at this level should be reported to your local adult social care service and raised as a safeguarding within the appropriate team - You may need to contact the police/emergency services.
Examples • Isolated incidents where the person is accidently given the wrong medication, given too much or too little medication or given it at the wrong time but no harm occurs. • Isolated incident causing no harm that is not reported by staff members. • Isolated prescribing or dispensing error by GP, pharmacist or other medical professional resulting in no harm.	Examples • Recurring missed medication or administration errors in relation to one service user that caused no harm. • Recurring prescribing or dispensing errors that affect more than one individual but cause no harm. • Concerns relating to allegations of over reliance on sedative medication to manage behaviour. • Covert medication without correct recorded	Examples • Recurrent missed medication or administration errors that affect one or more adult and/or result in harm. • Maladministration of medicines (e.g. sedation; insulin) • Covert administration without proper medical supervision or outside the Mental Capacity Act, with a detrimental impact • Pattern of recurring administration errors • Incident of maladministration that

	authorisation with no harm caused	results in ill-health or death. • Concern about Fabricated illness/ induced illness • Falsification of records or coercive/ intimidating behaviour to prevent reporting
Actions and outcomes Consult GP/ medical people. Training, complaints. Medication review.	Actions and outcomes Complaint, training. Medication review. Lessons learnt. Consult with GP/Pharmacy. Consult line manager. Commissioning referral with plan.	Actions and outcomes RAISE SAFEGUARDING CONCERN If there is an indication a criminal act has occurred the police MUST be consulted. Immediate safety plans must be implemented.

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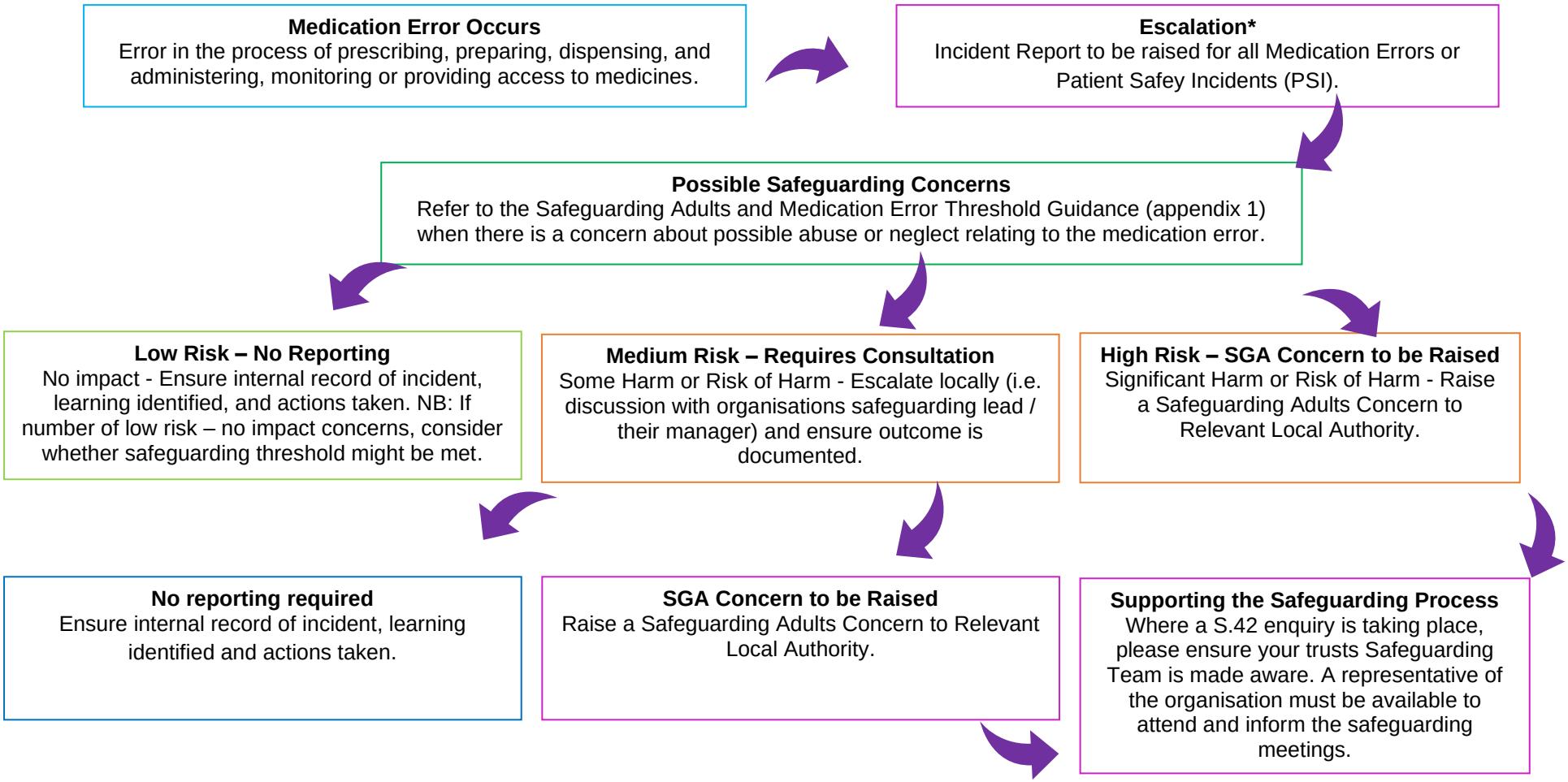
Appendix 2 – Flowchart for Protocol of Safeguarding Adults Enquiries and Medication Errors



Safeguarding Adults and Falls Protocol

1. Introduction

1.1. The Care Act 2014 defines Safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm, or neglect of adults. In the case of falls it is imperative to balance risk and the ability of people to live the lives they want to live. In the words of Justice Munby "What good is it making someone safe if it merely makes them miserable?"

1.2. Falls and injuries in hospital, community and residential settings are common due to physical frailty of adults at risk, the presence of a long-term condition such as Parkinson's disease, dementia, or arthritis, or being unfamiliar with the environment. There is strong evidence that a multifactorial falls risk assessment and an individualised multifactorial intervention care plan can reduce the risk of falls It is vital that all CQC regulated providers have well documented policies and protocols which highlight best practice in their organisation. Safeguarding is not a substitute for good local procedures.

1.3. The National Institute for Health and Care Excellence (NICE) have published a clinical guideline: Falls in older people: assessing risk and prevention (CG161) 2013 which covers case identification, multifactorial falls risk assessment and interventions. NICE have also published a Quality Standard: Falls in Older People (QS86) 2017 which covers prevention of falls and assessment after a fall in older people living in the community and during a hospital stay.

1.4. This protocol will enable health and social care staff to identify when a fall could have been caused as a result of neglect and whether an enquiry under the safeguarding procedures should take place.

2. Purpose of the protocol

2.1. This multi-agency protocol has been developed to assist in decision making as to whether to report a fall as a safeguarding concern. It provides good practice guidance to support all agencies in making a referral decision. It is not a substitute for organisations requirements to provide safe and effective care and to have an appropriate policy and procedures to guide staff.

2.2. Every organisation is responsible for ensuring that the protocol is used appropriately and monitor and review its use. This would include reviewing decisions to raise or not raise concerns within internal governance processes and managing risk of falls within the organisations policy.

3. Risk management of falls

3.1. The 2017 NICE Quality Standard defines a fall as an unexpected loss of balance resulting in coming to rest on the floor, the ground or on an object below the knee. A fall is distinct from a collapse which is as a result of an acute medical condition such as arrhythmia, transient ischaemic attack (TIA) or vertigo (suggest an alternative definition " A fall is defined as an event which causes a person to unintentionally rest on the ground or lower level and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard" (Falls: applying All Our Health).

3.2. Falls and fall related injuries are a common and serious problem for older people, particularly those with underlying conditions and pathologies. Falls are a major cause of disability and the leading cause of mortality for those aged 75 and above. Most falls do not result in injury but annually approximately

5% of older people living in the community who fall experience fractures or need hospitalisation. The Royal College of Physicians 2011 report (Falling Standards Broken Promises) highlight that falls and fractures in people over 65, account for 4 million hospital bed days each year in England alone.

3.3. People with care and support needs have an increased risk of falling compared to the general population due to their physical frailty, underlying medical conditions, muscle weakness, poor balance, medication, or unfamiliarity with a new environment.

3.4. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence, and mortality. Falling also has an impact on the family members and carers of people who fall. The consequences are exacerbated if people do not receive quick and appropriate assistance at the time of the fall.

3.5. Not all falls can be prevented but best practice requires that a multifactorial falls risk assessment should be in place as part of the overall care plan. This assessment and the care plan should be discussed and agreed with the person and their representative. If the person lacks the capacity to understand the risk assessment and proposed care plan then an advocate or representative should be consulted and agree the risk assessment and proposed plan using the principles of the Mental Capacity Act 2005.

3.6. In terms of a falls risk assessment, care planning and risk management, these should be undertaken at a number of key points in a person's journey of care for example:

- when the older person has a routine assessment and review with a health and social care practitioner.
- pre-admission to the hospital/care/nursing home/ intermediate care/home care.
- admission to the hospital/care/nursing home/ intermediate care/home care.
- at any point when the resident/service user's needs change.
- after a fall.

3.7. All organisations offering care and support in a hospital, community, own home, or care home setting should have a clear policy in place as to how falls are documented. It is recommended that this should be recorded as a specific incident which captures the following:

- Whether the risk assessment was up to date and the plan followed.
- Documents any harm and action taken to help the person at the time of the fall.
- The actions taken to prevent further falls.

4. Managing falls in context of adult safeguarding

4.1. Not all falls should be regarded as needing a safeguarding enquiry.

4.2. The threshold for adult safeguarding is met when; there is concern about possible abuse or neglect and; the adult has care and support needs and; the adult is unable to protect themselves as a result of the care and support needs. The following situations would trigger a safeguarding referral:

- Where a person sustains an injury due to a fall, and there is a concern that a multifactorial falls risk assessment and care plan were not in place or were not followed. The key factor is that the person has experienced avoidable harm.
- Where a person has fallen and appropriate medical attention has not been sought in a reasonable time frame and in accordance with the organisations policy,. Note: specific falls guidance states that where the person has sustained a head injury and/or suspected fracture, a medical assessment should always be arranged as a matter of urgency.
- Where there is concern that the circumstances and nature of the fall or explanation given are not consistent with the injury sustained.
- Where the organisations own post falls protocol is not in place or has not been followed.

4.3. A safeguarding concern does not need to be raised when:

- A person is found on the floor, there is no evidence of injury, and all care has been delivered in accordance with the falls policy.
- A fall is witnessed, and appropriate risk assessment is in place and has been followed.
- The falls is attributable to an acute medical condition or episode which has occurred recently i.e. in the past hours or days.
- The person made an informed decision about their own falls risk which is clearly documented.
- There was no risk assessment in place as this was not a foreseeable risk i.e. this is the first fall.

4.4. It must be acknowledged that there may be incidents where decision-making is not straightforward and professional judgement is required. This must take account of the principles of the Mental Capacity Act and that people have the right to make decisions that others may think are unwise, and they should not automatically be labelled as lacking the capacity to make a decision. In all cases ensure that the reasons for the decision are recorded clearly.

4.5. Where there is doubt as to whether the incident meets the threshold for adult safeguarding a referral should always be made.

4.6. In all cases a conversation needs to be held with the person who has fallen. This conversation should follow the principles of Making Safeguarding Personal and gain their views and desired outcomes.

5. Delegated enquires

5.1. The Care Act 2014 provides local authorities with the opportunity to “cause others to undertake enquiries”, which is referred to as “delegating responsibility” for leading safeguarding enquires. In the case of falls, in many instances health care professionals within the organisation responsible for that individual’s treatment will be best placed to lead these enquiries and so delegation should always be considered in the management of falls.

5.2. Where the fall meets the threshold, a safeguarding referral must be made to the local authority. The professional making the referral should have a discussion with the designated local authority decision maker as to whether there should be a multi-agency safeguarding enquiry or is if the enquiry should be delegated to the provider organisation. A summary of the discussion will be recorded by the local

authority and shared with the agencies involved in the discussion.

5.3. The principles of Making Safeguarding Personal should be adhered to and therefore there should be a discussion with the patient (and/or their representative or advocate as required) in terms of what they want to happen in terms of undertaking an enquiry. It should be clearly agreed who will have this discussion. In determining with whom it is most appropriate to hold the discussion, the principles of the Mental Capacity Act should be considered.

5.4. If the enquiry is delegated the partner should gather information and make a recommendation as to whether the fall constituted abuse or neglect. This should be completed by an appropriately skilled and trained person within the organisation.

5.5. The outcome of the fall's enquiry should be sent to the local authority. This will include information on:

- Whether the risk was removed, reduced, or remains.
- Whether the person's desired outcomes were met
- The impact of the enquiry on the persons sense of safety and well being
- The actions to be undertaken to embed learning.

5.6. The local authority officer will record the information from the delegated enquiry for reporting to the Safeguarding Adults Partnership Board.

5.7. If a full enquiry is to be undertaken the local authority will lead on the enquiry following local procedures.

6. Review

6.1. This protocol will be reviewed bi-annually.

7. References

Care Act 2014 c. 23. Available at: Care Act 2014 (legislation.gov.uk). [Last accessed 4th October 2024].

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Protocol on Safeguarding Adults Enquiries for different types of Pressure Ulcers

1. Introduction

Safeguarding adults is defined as 'protecting an adult's right to live in safety, free from abuse and neglect.' Adult safeguarding is about preventing and responding to concerns of abuse, harm, or neglect of adults.

Pressure ulcers develop when the skin integrity breaks down. This may be caused by poor practice, acts of omission or neglect but in some instances they are unavoidable.

This protocol will enable health and social care staff to identify if it is likely the pressure ulcer was caused as a result of neglect and whether an enquiry under the safeguarding procedures should take place. It will provide a focus on thresholds for referral through the safeguarding adult process. It is based on the multiagency integrated pressure ulcer pathway developed by NHS England (March 2024), in conjunction with National Wound Care Strategy Programme; Pressure Ulcer Recommendations and Clinical Pathways (May 2024); and the European Pressure Ulcer Advisory Panel; Prevention and Treatment of Pressure Ulcers/Injuries; Clinical Practice Guideline – The International Guideline 2019.

2. Purpose of the protocol

The protocol was developed by the South West London Integrated Care System and is recommended to be implemented by the five local Safeguarding Adult Boards.

This multi-agency protocol has been developed to assist in decision making as to whether to report a pressure ulcer as a safeguarding concern. It provides a 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.

It provides guidance for staff in all sectors who are concerned that a pressure ulcer may have arisen as a result of neglect/abuse or act of omission and therefore have to decide whether to make a referral to social services. Flow diagrams outlining the key elements of the protocol can be found in Appendix 1.

Each Safeguarding Adults Board and local organisations are responsible for ensuring that the protocol is used and adapted within their organisation appropriately, staff are trained to use it and to monitor and review its use. This would include reviewing decisions to raise or not raise concerns within internal governance processes.

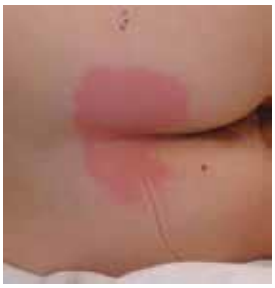
3. Pressure ulcers and safeguarding.

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.

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 considered.** All cases of actual or suspected neglect should be referred through the safeguarding procedures.

There are **Six** recognised categories of pressure ulcers in the Wound Classification system drawn up by the European Pressure Ulcer Advisory Panel – Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline – The International Guideline 2019. **Where there is multiple category 2; single or multiple category 3, 4 or unstageable pressure ulcers identified, the Adult Safeguarding Decision Guide (Appendix 2) should be completed.**

INTERNATIONAL NPUAP/EPUAP PRESSURE ULCER CLASSIFICATION SYSTEM (2019)

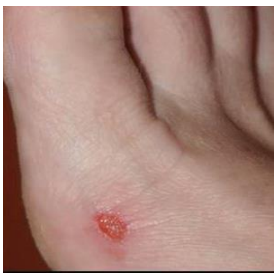


Category I: Nonblanchable Erythema

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; 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.

May indicate “at risk” individuals (a heralding sign of risk).

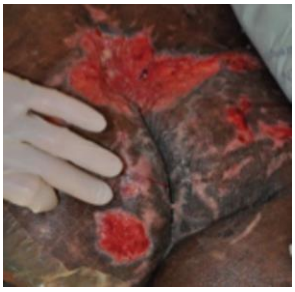


Category II: Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising.
* This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.

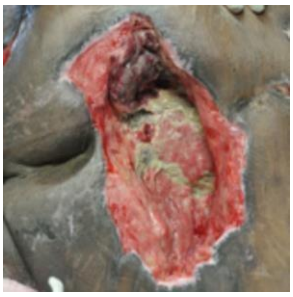
**Bruising indicates suspected deep tissue injury.*



Category III: Full Thickness Skin Loss

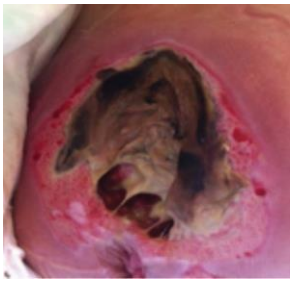
Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed.

Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a Category III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and Category III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category III pressure ulcers. Bone/tendon is not visible or directly palpable.



Category IV: 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 Category IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow. Category IV ulcers 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.

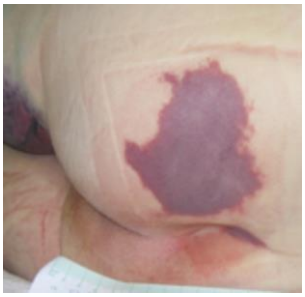


Uncategorisable: Depth Unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green, or brown) and/or eschar (tan, brown or black) in the wound bed.

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category, 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.

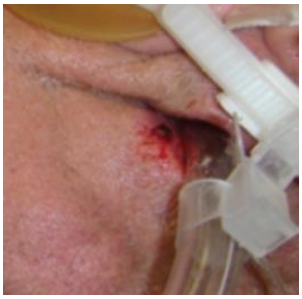


Suspected Deep Tissue Injury: Depth Unknown

Purple or maroon localized 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.

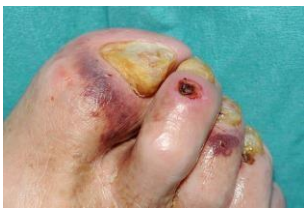
Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Other types of pressure or moisture related injury where safeguarding issues could be considered



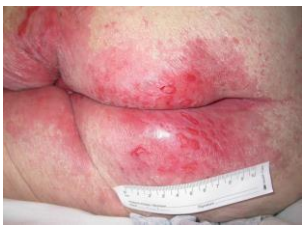
Mucosal Pressure Ulcer

Mucosal Pressure Ulcers occur in the moist membranes that line the respiratory, gastrointestinal, and genitourinary tracts. They do not have the same anatomical structures as the skin therefore it is not possible to categorise them. They should be recorded only as Mucosal Pressure Ulcer without the allocation of a number. Any potential safeguarding concerns related to Mucosal Pressure should be considered and discussed locally on a case-by-case basis, considering the protocol and professional judgement.



Device Related Pressure Injuries

Device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. Non-medical devices (i.e. bed clutter, furniture, and equipment) can also result in pressure injuries when they (usually inadvertently) remain in contact with skin and tissues. Any potential safeguarding concerns related to devices should be considered and discussed locally on a case-by-case basis, considering the protocol and professional judgement.



Moisture Associated Skin Damage (MASD)

MASD is the inflammation and erosion of the skin and results from prolonged exposure to different sources of moisture, such as faeces, urine, sweat, saliva, wound exudate, mucus, perspiration, digestive secretions, and other bodily fluids. Any potential safeguarding concerns related to MASD should be considered and discussed locally on a case-by-case basis, considering the protocol and professional judgement.

Images taken from NPAIP Pressure Injuries and Stages Poster (2016); NHS England and NHS Improvement Pressure Ulcer Categorisation Poster (2019)

Where a Mucosal Pressure Ulcer; Device Related Pressure Injury; or Moisture Associated Skin Damage (MASD) is identified, and there are concerns regarding omissions of care, poor care or neglect, a multi-disciplinary discussion should be conducted, and the adult safeguarding decision tool (appendix 2) used to support decision making around whether the concern meet the safeguarding threshold and subsequent referral to the local authority.

4. Managing Pressure Ulcers in context of Adult Safeguarding

As outlined in the NHS England 2024 Guidance, all cases of single Category 2 pressure ulcers require early intervention to prevent further damage. If there are concerns regarding poor practice, a clinical incident must be raised and investigated through the NHS provider organisations own procedures.

Any ungradable, or multiple category 2 or single Category 3 and 4 pressure ulcers MUST be reviewed under the pressure ulcer criteria and the PSIRF framework reported according to local clinical governance procedures.

In deciding about the need for a safeguarding referral in most settings, a history of the problem should first be obtained, contacting former care providers for information if the person's care has recently been transferred, and seek clarification about the cause of the damage.

The adult safeguarding decision guide should be completed by a registered nurse to consider if a safeguarding referral should be made if there is:

- Significant skin damage (i.e. Category 3 or 4, ungradable or multiple category 2s) and/or;
- There are reasonable grounds to suspect that it was avoidable, and/or;
- Inadequate measures taken to prevent development of pressure ulcer (including informal carers preventing access to care or services), and/or;
- Inadequate evidence to demonstrate the above

Safeguarding concerns should be raised when pressure ulcers are reported by anyone including carers, relatives, and patients, as any tissue damage no matter who reports it should be investigated appropriately using the adult safeguarding decision guide to support decision making.

As per above, where there are other types of skin integrity concerns identified (such as mucosal pressure ulcer, device related pressure injury, or moisture related skin damage) and there are concerns regarding omissions of care, poor care or neglect, a multi-disciplinary discussion should be conducted, and the adult safeguarding decision tool (appendix 2) used to support decision making around whether the concern meet the safeguarding threshold and subsequent referral to the local authority.

5. Procedure to determine if a pressure ulcer is due to neglect of an adult at risk.

The Pressure Ulcer Reporting Flowcharts can be found in Appendix 1. These outline the procedures where multiple category 2 or single / multiple category 3, 4 and unstageable pressure ulcers are identified and are designed specifically for different environments.

Health – Emergency Departments (Appendix 1)

It is recognised that Emergency Departments across the system are facing significant pressures, and the Health – Emergency Departments flowchart aims to support to reduce the pressure within these environments through effective multi-agency working when a pressure ulcer is identified and a person is returning home from the emergency department, whilst ensuring that safeguarding adults concerns are recognised and enquiries made.

Within an Emergency Department, when multiple category 2 or single / multiple category 3, 4 or unstageable pressure ulcers are identified and/or if staff have concerns regarding omissions of care, poor care or neglect, staff should complete relevant incident reporting within their organisation.

If unknown to services, a Registered Nurse (RN) within the emergency department should gather initial information and history (including from other setting if required) and complete local Risk Assessment and the Adult Safeguarding Decision Guide (Appendix 2).

If the person is known to services (i.e. district nursing or from a nursing home), a notification should be sent to relevant care provider who provided care prior to ED attendance and this agency should then complete the Safeguarding Decision Guide (Appendix 2).

If the adult safeguarding decision guide (appendix 2) score is below 15, the registered nurse should document decision making process and provide care as per local pressure ulcer policies. Advice and guidance by district nurses or TVNs will be provided as appropriate to the setting. It is good practice for a multidisciplinary discussion to be held where there is any doubt as to whether a safeguarding adults concern should be raised, despite the score, based on professional judgement.

Ongoing care and risk assessments, including specialist input should be provided as part of multi-agency working.

If the adult safeguarding decision guide (appendix 2) score is above 15, a safeguarding adults concern should be raised to the local authority where the safeguarding concern is alleged to have occurred, including the decision guide and any photographs taken within the referral to the local authority.

The Emergency department should ensure that relevant and appropriate referrals are made for safe discharge and ongoing care and treatment, which may include, tissue viability referral, adult social care support on discharge and care plan and risk assessment review by care provider as a part of immediate protection planning.

Where a Safeguarding adults enquiry or Section 42 enquiry is taking place, any involved agencies safeguarding adults' team should be made aware and engage and support the process.

Health – Inpatient (Appendix 1)

Within Inpatient settings when multiple category 2 or single / multiple category 3, 4 or unstageable pressure ulcers are identified, an incident report should be completed within internal incident reporting systems and referral to TVN, or specialist input should be completed. As a part of immediate protection planning, staff should also ensure that all required clinical input is undertaken.

A registered nurse should be allocated to gather initial information and history, which may include gathering information from another agency and confirming if the decision guide has already been completed. A risk assessment and the adult safeguarding decision guide (appendix 2) should be completed no later than 72 hours of identification of the pressure ulcer/s.

If the adult safeguarding decision guide (appendix 2) score is below 15, the registered nurse should document decision making process and provide care as per local pressure ulcer policies. It is good practice for a multidisciplinary discussion to be held where there is any doubt as to whether a safeguarding adults concern should be raised, despite the score, based on professional judgement.

If the adult safeguarding decision guide (appendix 2) score is above 15, a safeguarding adults concern should be raised to the local authority where the safeguarding concern is alleged to have occurred, including the decision guide and any photographs taken within the referral to the local authority.

Ongoing care and risk assessments, including specialist input should be provided as part of multi-agency working.

Where a Safeguarding adults enquiry or Section 42 enquiry is taking place, the Trusts safeguarding adults' team should be made aware and engage and support the process.

Community, Residential Care Home & Domiciliary Settings, Shared Lives, Supported Living and Inpatient Rehabilitation units (Appendix 1)

Within community settings including, residential care home and domiciliary settings, shared lives,

supported living and inpatient rehabilitation units, when multiple category 2 or single / multiple category 3, 4 or unstageable pressure ulcers are identified an incident report should be completed within internal incident reporting systems and CQC notification should be completed. As a part of immediate protection planning, staff should also ensure that all required clinical input is undertaken.

A referral should be made to district nursing (as urgent per NICE Guidelines) so that a registered nurse can gather initial information and obtain a history (including from other settings as required) and complete a local risk assessment and the adult safeguarding decision guide (appendix 2) no later than 72 hours following notification. Rationale for any delays should be clearly documented.

If the adult safeguarding decision guide (appendix 2) score is below 15, the registered nurse should document decision making process and provide care as per local pressure ulcer policies. Advice and guidance by district nurses or TVNs will be provided as appropriate to the setting. It is good practice for a multidisciplinary discussion to be held where there is any doubt as to whether a safeguarding adults concern should be raised, despite the score, based on professional judgement.

Ongoing care and risk assessments, including specialist input should be provided as part of multi-agency working.

If the adult safeguarding decision guide (appendix 2) score is above 15, a safeguarding adults concern should be raised to the local authority where the safeguarding concern is alleged to have occurred, including the decision guide and any photographs taken within the referral to the local authority.

Where a Safeguarding adults enquiry or Section 42 enquiry is taking place, the organisations safeguarding adults' team (if applicable) should be made aware and the organisation should engage and support the process.

Nursing Homes (Appendix 1)

Within nursing home settings, when multiple category 2 or single / multiple category 3, 4 or unstageable pressure ulcers are identified an incident report should be completed within internal incident reporting systems and CQC notification should be completed. As a part of immediate protection planning, staff should also ensure that all required clinical input is undertaken.

If the resident was admitted from another setting, the previous setting should be contacted to confirm if the adult safeguarding decision guide (appendix 2) has been completed. If not, the responsibility to complete the adult safeguarding decision guide is the responsibility of the registered nurse (RN) in the provider who has the client in the care. This should be completed no later than 72 hours after the pressure ulcer was identified, with the support of the previous setting in providing information as required.

If the adult safeguarding decision guide (appendix 2) score is below 15, the registered nurse should document decision making process and provide care as per local pressure ulcer policies. Advice and guidance by TVNs or specialist services should be sought as required. It is good practice for a multidisciplinary discussion to be held where there is any doubt as to whether a safeguarding adults concern should be raised, despite the score, based on professional judgement.

If the adult safeguarding decision guide (appendix 2) score is above 15, a safeguarding adults concern should be raised to the local authority where the safeguarding concern is alleged to have occurred, including the decision guide and any photographs taken within the referral to the local authority.

The nursing home should continue to manage the care plan, wound assessment and documents and should seek advice from TVN, GP or specialist services as required.

Where a Safeguarding adults enquiry or Section 42 enquiry is taking place, the organisation should engage and support the process as required.

6. Delegated enquiry

The Care Act 2014 provides local authorities with the opportunity to “cause others to undertake enquiries”, which is referred to as “delegating responsibility” for leading safeguarding enquiries, however they will retain ultimate duty in relation to the enquiry. In the case of pressure ulcers, in many instances health care professionals within the organisation responsible for that individual’s treatment will be best placed to lead these enquiries and so delegation should always be considered in the management of pressure ulcers.

When the Adult safeguarding decision guide (appendix 2) has been completed and there is no indication of neglect, the completed screening tool should be stored in the patient’s notes and a record kept of the screening outcome.

Where there is a cause for concern, a safeguarding referral must be made to the local authority. You will be invited to a planning meeting where a decision may be made to delegate responsibility. A summary of the discussion will be recorded by the local authority and shared with the agencies involved in the discussion.

If the enquiry is delegated to the reporting health partner, the work of the enquiry will involve either a concise or a comprehensive After-Action Review. This should be completed by an appropriately skilled and trained person such as District nurse team lead, ward manager or nursing home manager in line with the providers pressure ulcer or risk management policies.

The principles of Making Safeguarding Personal should be adhered to and therefore there should be a discussion with the patient (and/or their representative or advocate) in terms of what they want to happen in terms of undertaking an enquiry. It should be clearly agreed who will have this discussion. In determining who it is most appropriate to hold the discussion with the principles of the Mental Capacity Act should be considered.

The outcome of the After-Action Review findings should be sent to the local authority. This will include information on:

- Whether the person did or did not experience abuse or neglect
- Whether the person’s outcomes were met
- The impact of the enquiry on the person’s sense of safety and well being
- The actions to be undertaken to embed learning.

The local authority officer will record the information from the delegated enquiry for reporting to the Safeguarding Adults Partnership board.

If a full enquiry is to be undertaken the local authority will lead on the enquiry following local procedures.

7. Review

This protocol will be reviewed bi-annually. NB: This guidance has been developed based on the European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel guidance which is due to be reviewed and released in 2025 and should be updated based on any changes.

8. References

Care Act 2014 c. 23. Available at: Care Act 2014 (legislation.gov.uk). [Last accessed 4th October 2024].

Department of Health and Social Care, 2024. Safeguarding adults protocol pressure ulcers and raising a safeguarding concern. Available at: Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK (www.gov.uk). [Last accessed 26 September 2024]

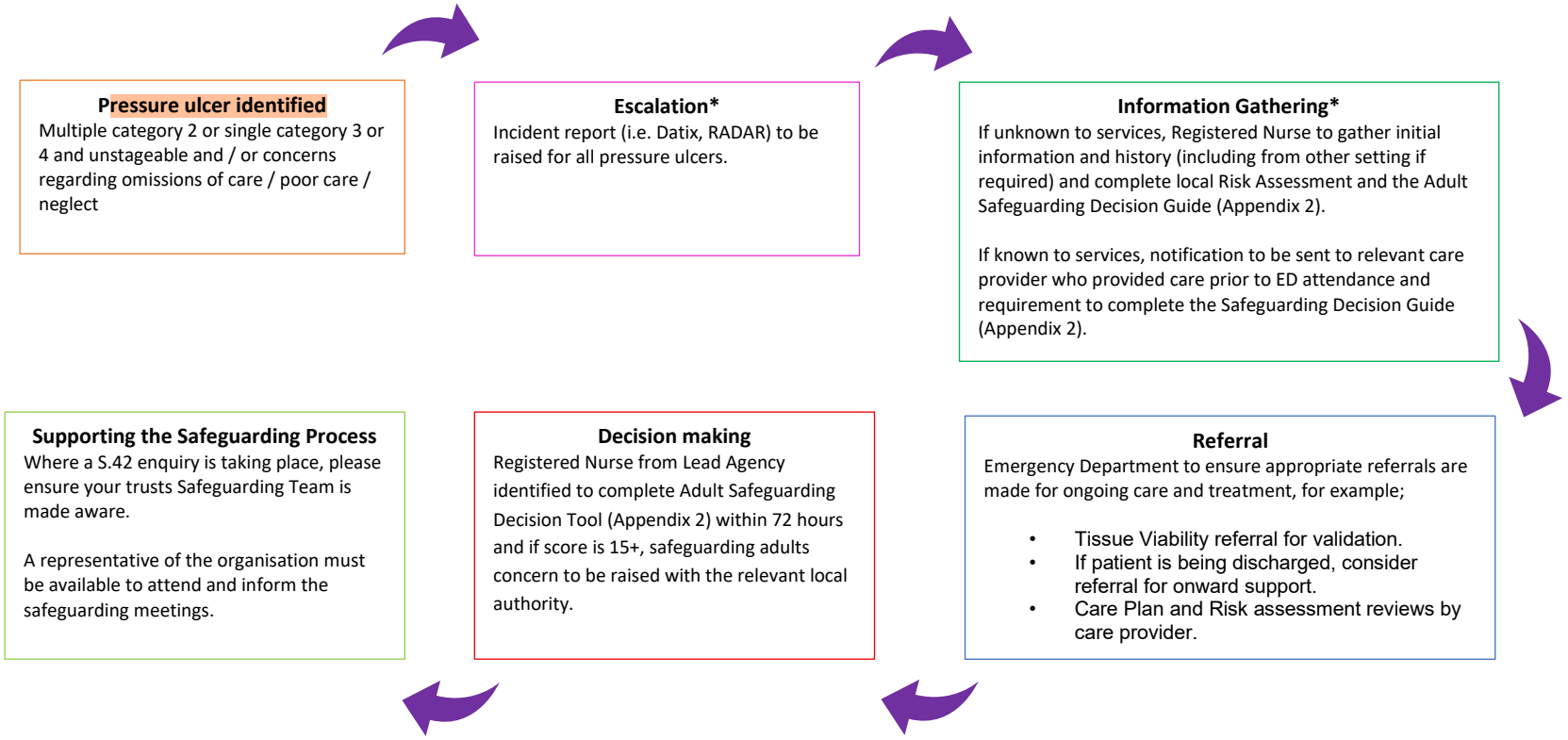
Department of Health, 2014. 'Care and Support statutory guidance; Issued under Care Act 2014', London: Department of Health. Available at: Care and support statutory guidance - GOV.UK (www.gov.uk) [Last accessed 4th October 2024]

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel, 2019. Clinical Practice Guideline and Quick Reference Guideline. Available at: 2019 Guideline — International Guideline [Last accessed 22nd October 2024]

National Institute for Health and Care Excellence (NICE), 2014. *Pressure Ulcers: prevention and management – clinical guideline.* Available at: Pressure ulcers: prevention and management [Last accessed 25 October 2024].

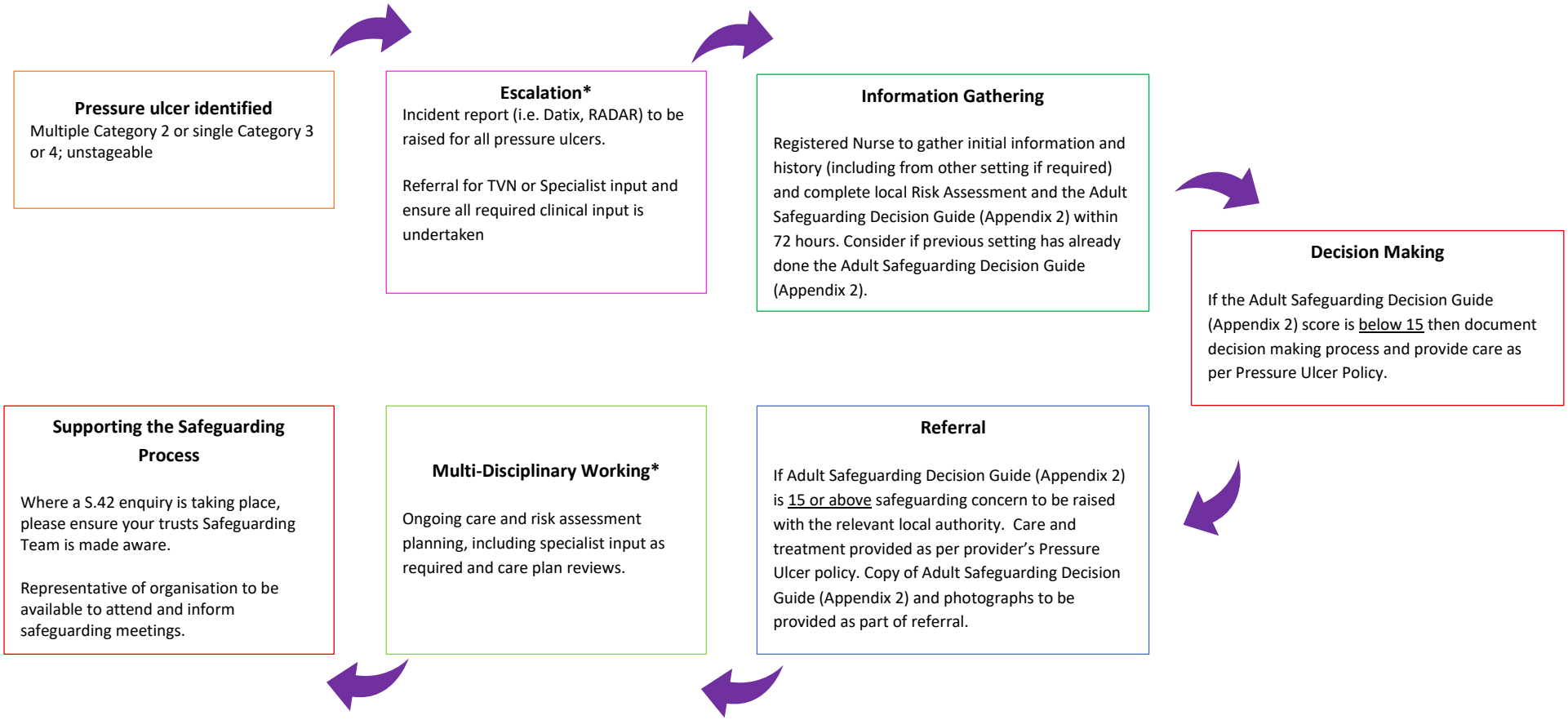
Appendix 1: Pressure Ulcer Reporting Flowchart

For use in Health (Emergency Departments)



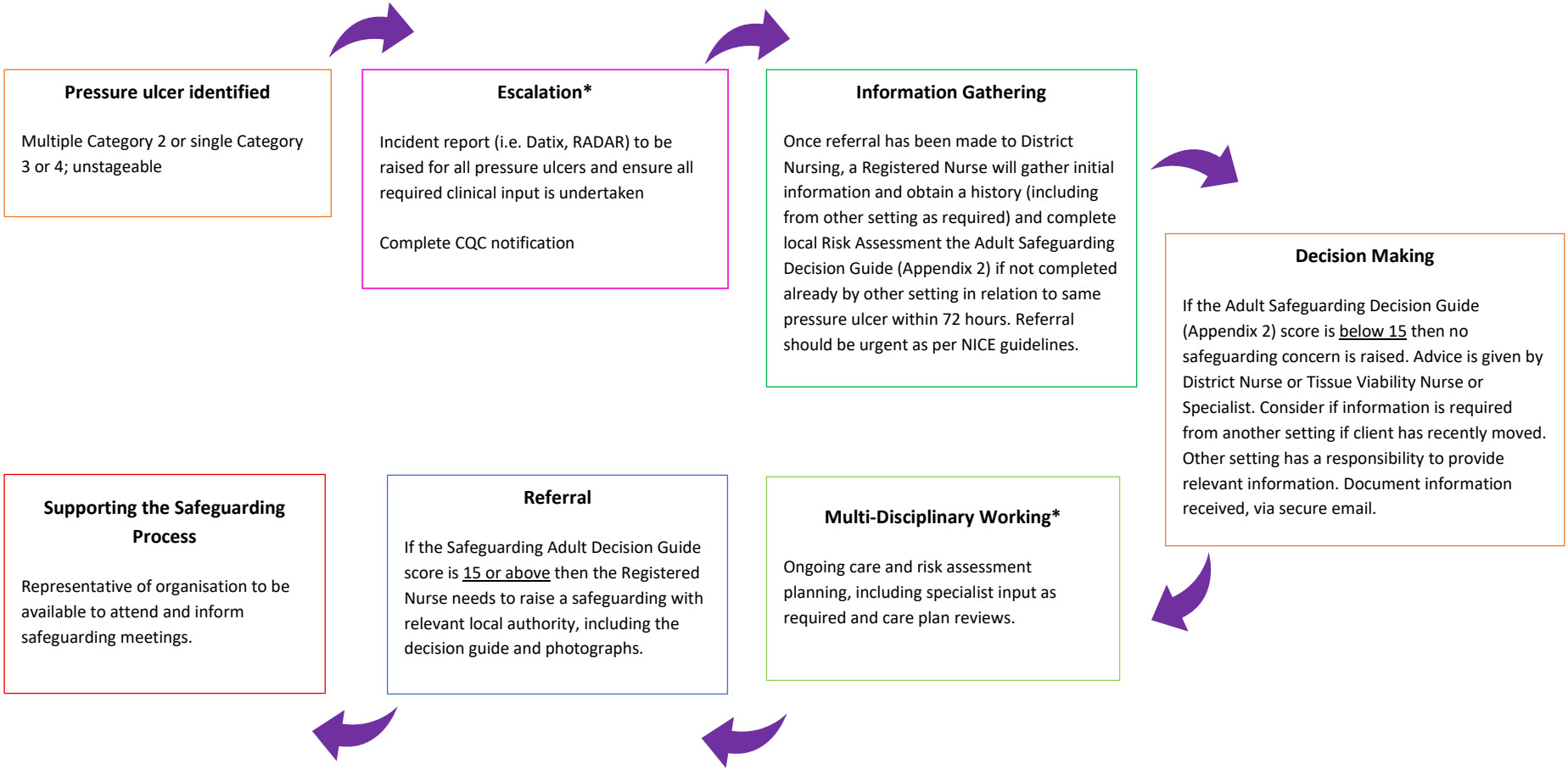
Pressure Ulcer Reporting Flowchart

For use in Health (In-Patient)



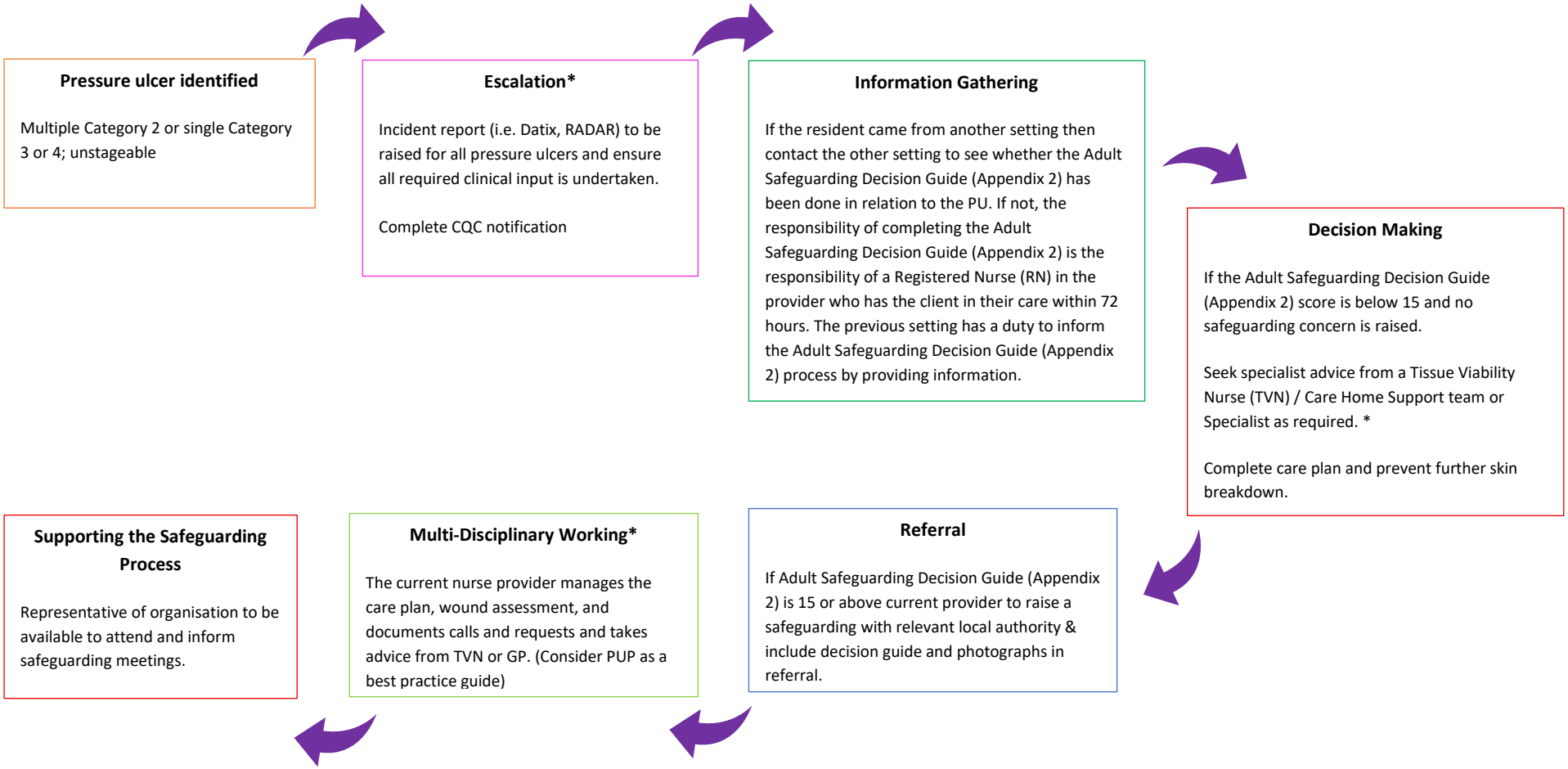
Pressure Ulcer Reporting Flowchart

For use in Community, Residential Care Home & Domiciliary Settings, Shared Lives, Supported Living and Inpatient Rehabilitation units



Pressure Ulcer Reporting Flowchart

For use in Nursing Homes



Appendix 2: Adult Safeguarding Decision Guide and Body Map

Risk category	Score	Evidence
1. Has the person's skin deteriorated to either category 3 or 4 or multiple sites of category 2 ulceration from healthy unbroken skin since the last opportunity to assess or visit? • No - For example, no previous skin integrity issues or previous contact with health or social care services) (score 0) • Yes - For example, record of blanching or non-blanching erythema progressing to category 2 or category 2 progression to category 3 or 4) (score 5)		
2. Has there been a recent change, that is within days or hours, in their clinical condition that could have contributed to skin damage? For example, infection, pyrexia, anaemia, end of life care (skin changes at life end), critical illness, emergency hospital visit. • Change in condition contributing to skin damage (score 0) • No change in condition that could contribute to skin damage (score 5)		
3. Was there a pressure ulcer risk assessment or reassessment with an appropriate pressure ulcer care plan in place, and was this documented in line with the organisation's policy and guidance? • Yes - Current risk assessment and care plan carried out by a healthcare professional and documented appropriate to person's needs. If the person is not under the care of a healthcare professional, the carer responsible has screened for risk and implemented preventative care accordingly. (score 0) • Yes - Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed (score 5)		State the elements of care plan that are in place

• No or Incomplete - No or incomplete Risk assessment and / or care plan (score 15)		
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? • No or Not Applicable (score 0) • Yes (score 15)		
5. Is the level of damage to skin inconsistent with the person's risk status for pressure ulcer development? For example, no risk factors that align with the category of pressure ulcer that has developed. • Skin damage less severe than person's risk assessment suggests is proportional (score 0) • Skin damage more severe than person's risk assessment suggests is proportional (score 10)		
Question 6 has 2 parts - which part you ask depends on the person: if the person has capacity to consent to every relevant element of the care plan, answer question 6a. if the person has been assessed as not having mental capacity to consent to any or some relevant aspects of the care plan, answer 6b		
6A. Were the risks and benefits explained and understood by the person? Was a plan of care agreed in line with shared decision making and has the person chosen to follow the relevant aspects of the plan? • Person has followed care plan, and local policies to support shared decision making have been followed (score 0) • Person followed some aspects of care plan but not all (score 3)		

• Person has not followed care plan or not given information to enable them to make an informed choice, or an opportunity to discuss reasons for not following the agreed plan and alter the plan accordingly has not been taken (score 5)		
6B. Was the relevant care undertaken in the person's best interests, following the best interest's checklist in the Mental Capacity Act? This should be supported by documentation - for example, capacity and best interest statements and record of care delivered. • Documentation of care being undertaken in person's best interests (score 0) • No documentation of care being undertaken in person's best interests (score 10)		
Total score		

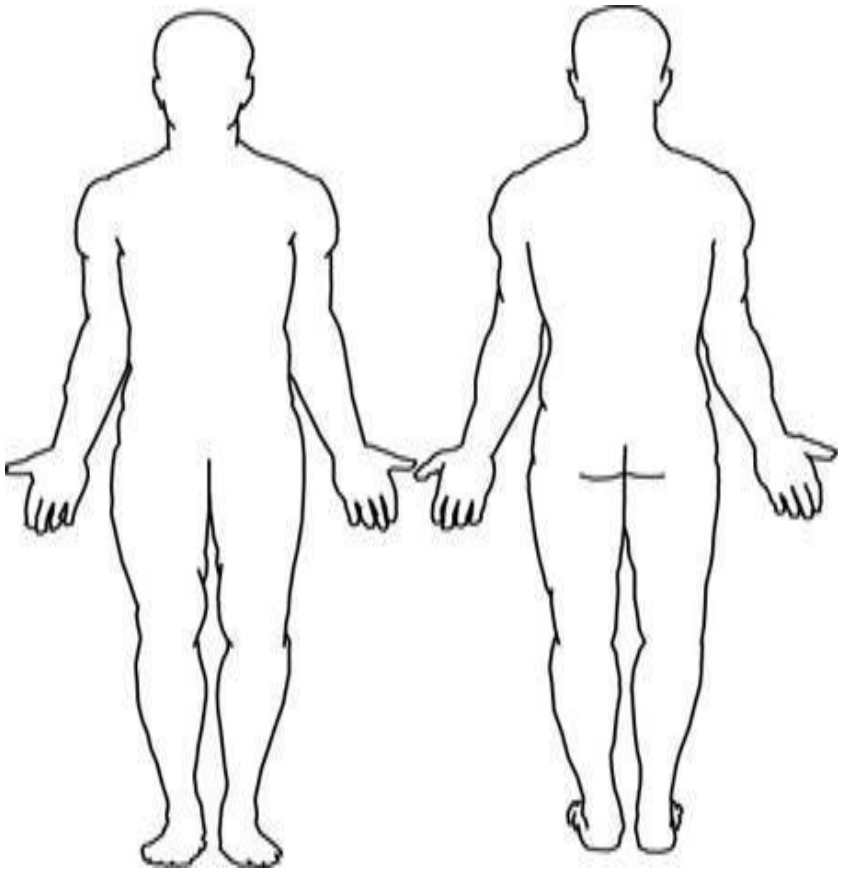
Score conclusion

If the total 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 person's notes.

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



Patient name: _____

Patient NHS/ Hospital number (if known): _____

Name of assessing nurse (PRINT): _____

Job Title: _____

Signature: _____

Name of second assessor (PRINT): _____

Job title: _____

Signature: _____

Adult Safeguarding Decision Guide - GUIDANCE NOTES

It is important to agree a timescale for when the Appendix 2 needs to be completed, and this tool is devised to be used as a check list and not an enquiry. Completion of the tool promotes and demonstrates partnership working.

Colleagues from within the South West London Integrated Care System agreed that the Adult Safeguarding Decision Guide should be completed no later than 72 hours after the pressure ulcer was identified.

1. Concern is raised that a person has severe pressure damage:

Category 3, 4, unstageable, suspected deep tissue injury or multiple sites of category/grade 2 damage (EPUAP, 2019)

2. Complete adult safeguarding decision guide and raise an incident immediately as per organisation policy.

Score 15 or higher: Concern for safeguarding

Above 15

Discuss with the person, family and/ or carers, that there are safeguarding concerns and explain reason for treating as a concern for a safeguarding enquiry has been raised.

1. Refer to local authority via local procedure, with completed safeguarding pressure ulcer decision guide documentation.
2. Follow local pressure ulcer reporting and investigating processes.

Record decision in person's records.

Less than 15

Discuss with the person, family and/ or carers, and explain reason why not treating as a safeguarding enquiry.

Explain why it does not meet criteria for raising a safeguarding concern with the Local Authority, but then emphasis the actions which will be taken.

1. Action any other recommendations identified and put preventative/ management measures in place.
2. Follow local pressure ulcer reporting and investigating processes.

Record decision in person's records.

*PLEASE SHARE AND DISPLAY THE RELEVANT FLOWCHART TO STAFF**

- Health in Patient Care (Hospital)
- Health in Accident and Emergency and Day Settings (such as day surgery and outpatient appointments)
- Community Health Care, Residential Domiciliary & Care (including supported living and shared lives)
- Nursing Home Care

Appendix 3: Key contacts

Borough	Organisation	Team	Contact details
Croydon	Adult Social Care	Adult Social Care	Adult health and social care | Croydon Council
Croydon	Croydon University Hospital - Acute	Safeguarding Adults Team	ch-tr.safeguardingadults@nhs.net
Croydon	Croydon University Hospital – Community Services	Safeguarding Adults Team	ch-tr.safeguardingadults@nhs.net
Kingston	Adult Social Care	Access and Safeguarding Team	Adult safeguarding - Report a concern about an adult – www.kingston.gov.uk
Kingston	Kingston Hospital	Kingston Hospital Adult Safeguarding Team:	khft.safeadults@nhs.net
Kingston	Kingston Hospital	Kingston Hospital Tissue Viability Team:	khft.tissueviabilityteam@nhs.net
Kingston	Your HealthCare	Single Point of Access (SPA)	SPA@yourhealthcare.org Tel: 020 8274 7088 Fax: 020 8390 6923
Merton	Adult Social Care	Safeguarding Adults Team	Safeguarding.adults@merton.gov.uk
Merton	CLCH	Merton Single Point of Access	clcht.mertonspa@nhs.net
Merton	CLCH	Merton TVN Team	clcht.mertontvnurses@nhs.net
Merton	CLCH	Safeguarding Team	clcht.adultsafeguarding@nhs.net
Richmond	Adult Social Care	First Contact	adultsocialcare@richmond.gov.uk
Richmond	West Middlesex Hospital	Safeguarding Team	Email: Chelwest.safeguardingteam@nhs.net Phone: 020 3321 5659 / 020 8321 5312 Mobile: 07771 378 344 / 07500 066 517
Richmond	Richmond Community Health Services	Safeguarding Team Tissue Viability Team	hrch.safeguarding@nhs.net hrch.TissueViability@nhs.net
Sutton	Adult Social Care	Adult Social Care First Contact	AFCSSafeguarding@sutton.gov.uk

Sutton	St Helier Hospital	Tissue Viability Team	est-tr.tissueviability@nhs.net
Sutton	Sutton Health and Care	SHC Safeguarding SHC Tissue Viability	esth.communitysafeguarding@nhs.net esth.shctissueviability@nhs.net
Wandsworth	Adult Social Care	First Contact	adultsocialcare@wandsworth.gov.uk
Wandsworth	St Georges Hospital	Tissue Viability Team Adult Safeguarding Team Switchboard	tissueviability@stgeorges.nhs.uk 020 8725 2230 safeguarding.adultsteam@stgeorges.nhs.uk 020 8725 1624 020 8725 2666 020 8672 1255
Wandsworth	CLCH	Tissue Viability Team Safeguarding Team	clcht.tvn@nhs.net clcht.adultsafeguarding@nhs.net