Guidance Note 21: Tissue Viability Thresholds for Referral to the Safeguarding Adults Process

21.1 Introduction

21.1 This protocol has been written to provide a framework for decision making in relation to establishing the need for raising a safeguarding referral in the event of tissue damage occurring.

21.2 What is Safeguarding?

21.2.1 Safeguarding can be defined as action to prevent abuse or to protect persons thought to be at risk of abuse or neglect or poor standard of care by another person, or persons, that violates their human and civil rights (BSAB, 2009).

‘Promote and protect individual human rights, independence and well-being and secure assurance that the adult at risk stays safe, are effectively safeguarded against abuse, neglect, discrimination, embarrassment or poor treatment, are treated with dignity and respect and enjoy a high quality of life’(BSAB, 2009)

21.3 Who is a vulnerable adult (adult at risk)?

21.3.1 Vulnerable adult is a term used to describe a person who is:

- An adult aged 18 or over
- And who is, or may be in need of community care services, because of frailty, learning or physical disability, sensory impairment or mental health difficulties.
- And who is, or may be unable to take care of him or herself or take steps to protect him or herself from significant harm or exploitation. (DOH, 2000)

21.4 What is neglect?

21.4.1 ‘Serious harm being caused by acts or omissions that could have been reasonably avoided’ (Derby and Derbyshire Safeguarding Vulnerable Adults Partnership, (2006.)

21.4.2 Pressure ulcers are cited in the Safeguarding Adults: multi-agency policy and procedures for the West Midlands as:

- Neglect and acts of omission: section 3.8.1 Person’s physical condition/appearance is poor (e.g. ulcers, pressure sores, soiled or wet clothing).
21.5 What is a Pressure Ulcer?

21.5.1 A localised area of damaged tissue as a result of pressure in combination with other variables of which there are 4 grades:

**Category/Stage 1: Non-blanchable 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 1 may be difficult to detect in individuals with dark skin tones. This may indicate “at risk” persons.

**Category/Stage II: Partial thickness**

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 or serosanguinous 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, incontinence associated dermatitis, maceration or excoriation.*Bruising indicates deep tissue injury.
Category/Stage 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/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/Tendon is not visible or directly palpable.

Category/Stage IV: Full thickness tissue loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable. (EPUAP, 2009)
21.6 Notification Required

21.6.1 Primary/Secondary Care

A clinical incident form should be completed for all grade 2, 3 and 4 pressure ulcers in line with the National Institute for Health and Clinical Excellence (NICE, 2005).

21.6.2 Care Homes / Care Homes with Nursing

Care Quality Commission (CQC, 2009), state that any serious injury to a service user including the development of grade 3 and 4 pressure ulcers must be notified to them by completing a Regulation 18 (The Care Quality Commission (Registration) Regulations 2009).

21.6.3 Additional Actions required

Where there are grade 3 or 4 pressure ulcers, a Root Cause Analysis (RCA) or a Risk Assessment must be undertaken to identify whether reasonable steps were taken to prevent the damage of the development of the pressure ulcer (see Section 21.8 below).

21.6.4 Where a service user has developed a Grade 3 or Grade 4 EPUAP pressure ulcer, consideration should be given to the possibility of neglect and the potential need for a safeguarding referral. If reasonable steps were not taken / cannot be evidenced then a Safeguarding Alert should be raised with Adults and Communities Directorate, Birmingham City Council (A&CD, BCC).

21.7 Safeguarding in relation to Tissue Viability

21.7.1 Potential indicators for a safeguarding referral:

- Development of a Grade 3/4 EPUAP pressure ulcer
- Rapid onset/deterioration of tissue damage
- Unexplained weight loss/dehydration
- Unexplained bruising or injuries of any sort
- Poor physical condition i.e. failure to attend to physical needs such as toileting, dressing and washing
- Poor continence management
- Burns
- Leaving a resident unattended for an extended length of time
- This is not an exhaustive list and there may be other areas of Tissue Viability that would trigger a Safeguarding Alert.
21.7.2 The presence of any of the above indicators must be treated as a matter of concern. Staff may not be sure whether to raise a Safeguarding Adults Alert – if in doubt call and discuss the indicators and/or concerns.

21.8 Reasonable measures that should be taken to prevent tissue damage

21.8.1 The following points are considered reasonable prevention measures however each situation will need to be considered on an individual basis:

- Referral of all grade 3 and grade 4 EPUAP pressure ulcers to the Tissue Viability Service
- Implementation of, or increase in repositioning regime, with clear documentation
- Evidence of a 24 hour approach to repositioning at regular intervals, appropriate to each individual
- Regular skin inspection, and clear documentation, to include continence management and protection of skin with barrier creams and/or emollients
- Appropriate plan of care which is updated accordingly and addresses the cause of the pressure damage.
- Care Homes: Monthly risk assessment acknowledging changes in need
- Primary care: Three monthly risk assessment, or as clinical condition changes, acknowledging changes in need.
- Appropriate equipment with supporting documentation
- Nutritional assessment and involvement of necessary professionals
- Wound assessment and evaluation to include photographs and regular wound measurements
- Appropriate dressing selection with a treatment chart
- Pain assessment and liaison with the GP
- Documented evidence of offering care to non concordant residents

Absence of any of the above may indicate a safeguarding referral but would be considered on an individual basis.

Where a person develops a grade 3 or 4 pressure ulcer and there is no evidence of appropriate/ reasonable measures to prevent the damage then a Safeguarding Alert must be raised.
21.9 Factors that may influence the safeguarding referral decision

21.9.1 Despite reasonable measures being taken in some cases pressure ulcer development may be not have been preventable due to physiological changes or non concordance, for example:

- Palliative diagnosis
- End of life care
- Non concordance with recommended treatment and interventions
- Multiple co-morbidities
- Change in condition
- History of pressure ulcer development
- Mental Capacity issues
- Mental Health issues

In cases where one or more of the above are present reasonable measures (see section 21.8) still need to be carried out and be documented. The absence of reasonable measures would indicate the need for a Safeguarding Alert.

Where the person is non-compliant consideration must be given to assessing the person’s mental capacity to understand the implications of their behaviour and/or whether they have a mental health issue which is affecting their ability to comply. In either of these circumstances, staff must seek further advice.

21.10 Consideration of Mental Capacity

If a person lacks capacity to make a decision in relation to the care or treatment of the pressure sore, it is the responsibility of the practitioner to act in the best interests of the patient. (Refer to own Mental Capacity Act Policy).

Please see:

Appendix 1 for further information on the internal process and
Appendix 2 for across agency process (below)
21.11 References

- Birmingham Safeguarding Adults Board (BSAB) (2010), Safeguarding Adults: Policy, Procedure and Good Practice Guide.

- Care and Quality Commission (2009). Guidance for Providers: How to tell us about notifiable events. DOH.


- Derby and Derbyshire Safeguarding Vulnerable Adults Partnership, (2006)

- All of the photographs in 'Guidance Note 21' were first used in Pressure Sore Classification 2 and appear courtesy of the European Pressure Ulcer Advisory Panel. Available at http://www.puclas.ugent.be/puclas/e/ (accessed 26 February 2013).


Contact points

- Birmingham City Council (BCC) Adults & Communities: BCC is the lead agency for receiving and co-ordinating Safeguarding Adults alerts, assessments and investigations.

  Please see www.bsab.org for contact details

- Tissue Viability Team:
  Refer to your local Tissue Viability Team / link for advice

- Safeguarding Adults Team
  Refer to your local Safeguarding Adults team / link for advice
Appendix 1
Safeguarding Referral Pathway for pressure ulcers within own agency

Any tissue damage, including bruising or injury needs to be considered on an individual basis. A referral should be made when deemed appropriate following the Safeguarding Adults Multi Agency procedures.
Appendix 2

‘Across Agency’ Clinical Governance Framework for integrated working on grade 3 and 4 pressure ulcers

Grade (category) 3 or 4 pressure ulcer identified. Was the pressure ulcer present on admission to your service or developed within 72 hours of admission to your service?

YES

Complete Incident Form

NO

Follow Appendix 1 flowchart

Was there professional input / involvement at the origin of referral?

YES

Did they complete an Incident Form / Root Cause Analysis? Were you informed that the person had a Pressure Ulcer prior to admission to your service (verbal or tissue Viability Transfer Letter)?

YES

Document Share information on a need to know basis

NO

Make a Safeguarding Alert

Follow Appendix 1 flowchart

Contact referrer to discuss. If not confident pressure ulcer was identified or actions were taken – make a Safeguarding Alert