In Partnership with the Safeguarding with Providers Group
a sub group of Lancashire Safeguarding Adults Board

Best Practice Guidance for Safeguarding Individuals with Pressure Ulceration

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Executive Summary

This guidance has been designed to support practitioners, care providers and social care teams to provide assistance when there is concern about pressure ulceration and when this becomes a safeguarding matter.

Safeguarding relates to the need to protect individuals who may be in vulnerable circumstances. These are adults in need of care and support who may be at risk of abuse or neglect, due to the actions (or lack of action) of another person. In these cases, it is essential that local services work together to identify people at risk, and put in place interventions to help prevent abuse or neglect and to be able to protect people.

The Care Act 2014 requires agencies to work together to develop shared strategies for safeguarding vulnerable adults. All health, social care professionals and care workers play a key role in safeguarding of vulnerable adults who are in receipt of health or care services. It is everybody’s responsibility to protect vulnerable adults from abuse, harm and omissions of care.

This best practice tool will provide guidance for practitioners, when there is concern that pressure ulceration may have resulted from poor practice or neglect. Early reporting is essential to ensure appropriate corrective action is taken and to prevent the reoccurrence of pressure ulceration and further harm. The tool will standardise practice across services in relation to the safeguarding response in individuals where there is pressure ulceration. It will support a consistent approach to the evaluation of incidents involving pressure ulceration. It will also support health, social care professionals and care staff in decision making and in the identification of harm when an omission of care has taken place or where there has been a failure to undertake the required holistic assessment and risk assessments of an individual’s care and treatment needs.

Principles of Good Practice

All commissioners and providers of services working with vulnerable adults have a responsibility to safeguard individuals from the risk of abuse or neglect and promote health and wellbeing. This includes the prevention and management of pressure ulcers.

- Care and support needs must be addressed by enabling patients to access appropriate services wherever possible in respect to promotion of tissue viability and associated risk factors.
- Additional support needs must be met by the timely provision of specialist assessments /risk assessments where required.
- Agency responses must be needs-led, with focus on the principles outlined in the Mental Capacity Act 2005 and the Human Rights Act 1998.
• Equality and diversity promotes equal opportunity for all, by giving individuals the chance to achieve their full potential free from prejudice and discrimination. Equality and Diversity must be valued and fully considered in all agency responses.

Safeguarding Adults Legislation and Guidance

The Safeguarding Vulnerable Groups Act (2006) recognises that any adult receiving any form of healthcare is vulnerable. No secrets guidance (DH 2000) has now been replaced by The Care Act 2014. Safeguarding duties apply to an adult who:

• has needs for care and support (whether or not the local authority is meeting any of those needs)
• is experiencing, or at risk of, abuse or neglect
• 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.

Safety from harm and exploitation is one of our most basic needs. “Safeguarding” refers to a range of activity aimed at upholding an adult’s fundamental right to be safe. It is of particular importance for people who, because of their situation or circumstances, are unable to keep themselves safe.

Clinical Governance and safeguarding (DH 2010) highlighted an absence of adult safeguarding systems within the NHS. It is important that healthcare incidents that raise safeguarding concerns are considered and reported via the safeguarding procedures and any lessons learnt are implemented. Healthcare professional’s contribution to this process is invaluable in the identification of best practice and provision of on-going care and treatment.

All health provider organisations have a responsibility to develop local robust arrangements to ensure that adult safeguarding becomes fully integrated into health systems. This will result in greater openness and transparency about clinical incidents, learning from safeguarding concerns that occur within health services and better clarity on reporting with more improved positive partnership working.

Safeguarding adults is shaped by 6 principles (DH 2011)

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Proportionality and least intrusive response appropriate to the risk presented

Principle 5: Partnerships

Local solutions through services working with communities

Principle 6: Accountability

Accountability and transparency in delivering safeguarding

The Care Act 2014 defines wellbeing in relation to an individual to any of the following:

(a) Personal dignity (including treatment of the individual with respect);
(b) Physical and mental health and emotional well-being;
(c) Protection from abuse and neglect;
(d) Control by the individual over day-to-day life (including care and support, or support, provided to the individual and the way in which it is provided);
(e) Participation in work, education, training or recreation;
(f) social and economic well-being;
(g) Domestic, family and personal relationships;

Abuse is defined as a violation of an individual’s human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts.

The Care Act defines ten categories of abuse. For the purpose of this tool the following are applicable for individuals at risk of pressure ulcers.

Physical abuse – including assault, hitting, slapping, pushing, misuse of medication restraint or inappropriate physical sanctions

Organisational abuse – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

Self-neglect – this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.
**Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

**Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

The Mental Capacity Act 2005 introduces two criminal offences of ill treatment and willful neglect of a person who lacks capacity to make relevant decisions (section 44). The offences can apply to anyone caring for a person lacking capacity; this can include family members, carers, health/social care staff, an attorney appointed under lasting power of attorney, enduring power of attorney, or a court appointed deputy. It is important that all practitioners pay regard to the Act in supporting vulnerable adults to make decisions or applying the best interest process where adults are not able to consent to their care or treatment.

Willful neglect can be an intentional or deliberate or reckless act or omission or failure to carry out an act of care by someone who has care of a person who lacks (or whom the person reasonably believes lacks) capacity to care for themselves. The penalty for ill treatment or willful neglect can range from a fine or a prison sentence for up to 5 years. Health care professionals need to be mindful of this and vigilant in following their regulatory bodies’ codes of conduct and organisational policies and procedures.

**Pressure Ulceration**

**Definition**

“A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear” (EPUAP, 2009).

Pressure ulcers represent a significant cost burden, both to patients and to health care providers. The cost of treating individual pressure ulcers is estimated to vary from £1,214 to £14,108 depending on severity (Dealy, Posnett, Walker, 2012). The Department of Health has issued ten High Impact Actions (2010), including ‘your skin matters’ aimed at preventing pressure ulcers and implemented the Safety Thermometer (2013/14) aimed at achieving harm free care.

The Department of Health has defined avoidable and unavoidable pressure ulcers as per the following:

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

- evaluate the person’s clinical condition and pressure ulcer risk factors, including the individual’s skin integrity, risk of pressure damage, mobility status, nutritional and hydration status, continence needs and pain management needs;
- plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate and consult with nursing/ tissue viability or medical advice as appropriate.

**Unavoidable Pressure Ulcer:** “Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care undertook the following:

- had evaluated the person’s clinical condition and pressure ulcer risk factors;
- planned and implemented interventions that are consistent with the persons needs and goals and recognised standards of practice;
- monitored and evaluated the impact of the interventions; and revised the approaches as appropriate;
- or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence

**Guidance:**
In determining whether the pressure ulcer is avoidable; commissioners, regulators or others could request to see evidence demonstrating the actions outlined in the “avoidable” definition are demonstrated.

If there is evidence of poor care and or neglect the provider is required to report this as a safeguarding adult alert into Lancashire Local Authority safeguarding enquiry team and to the Care Quality Commission. Where there are identified risk factors for other individuals associated with pressure ulcer development then individual holistic health needs assessment must be undertaken where appropriate.

**Principles of Prevention:** (SSKIN – Skin assessment; Support surface; Keep moving; Incontinence; Nutrition and hydration)

1. **Skin assessment**
   The skin must be assessed regularly. Frequency must be based on vulnerability and condition of the patient. All vulnerable areas must be inspected. Patients (or carers) must be encouraged to do this using a mirror if necessary.
If persistent erythema, non-blanching erythema, blisters, purplish/blue localised areas etc. are identified then pressure damage has occurred and care plans must be revised to reflect the increased risk. In darker skin pressure damage may be more difficult to identify, consider heat, swelling, induration and altered pigment.

2. Support Surface

Consider all surfaces used by the patient ensuring that the patient has 24 hour access to pressure relieving devices and/or strategies for pressure relief. Choice of support surface must be on the basis of:

- Risk assessment
- Pressure ulcer assessment
- Location and cause of pressure ulcer
- Skin assessment
- General health
- Mental health
- Lifestyle and abilities
- Acceptability and comfort
- Availability of carer / patient to reposition
- Patient weight
- Cost consideration

3. Keep Moving

Consider mobilising, positioning and repositioning interventions for all patients (including those in beds, chairs and wheelchair users). Acceptability to the patient and the needs of the carer must be taken into account. Consider whether sitting time must be reduced to less than 2 hours per session, based on risk assessment and skin assessment.

Patients must be provided with education and information on pressure ulcer risk reduction such as positional changes. Consider passive movements for patients with compromised mobility. The patient must be informed of how they can contact a health care professional if they have any concerns.

Limit head-of-bed elevation to 30 degrees for an individual confined to bed, unless contraindicated by medical condition. Encourage individuals to sleep in a 30 to 40 degree side-lying position or flat in bed if not contraindicated.

Use transfer aids to reduce friction and shear. Use a hoist to lift - don't drag - the individual while repositioning. Do not leave moving and handling equipment under the individual after use unless the equipment is specifically designed to do so. When using slide sheets, full length body slide sheets offer full protection from shearing forces including heels.
4. Incontinence/moisture

Moisture lesions are often confused with pressure ulcers as moisture may be a factor in their development. However, lesions may occur solely due to moisture from incontinence of urine and/or faeces. It is important to differentiate between the two as management strategies differ.

- Continence assessment
- Implement barrier wash/cream/spray
- Consider possibility of bladder/bowel infection
- Do not use thick antiseptic cream on the skin as it may interfere with the absorbency of an Incontinence pad
- Use suitable pads and retainers for patient

5. Nutrition and hydration

Ensure nutritional status has been assessed as part of a holistic assessment. Provide nutritional support to patients with an identified deficiency. Obtain support and guidance from dietician where appropriate.

Many people admitted to hospital have an impaired nutritional intake due to functional or psychological issues. Research has shown that nutritional status deteriorates in hospital, particularly in older people.

Malnutrition has direct influence on the development and severity of pressure ulcers. Skin tolerance is also reduced by dehydration, decreased calorie intake and a fall in serum albumin; this increases the risk of skin breakdown and delays wound healing.

Best Practice Indicators for Care and Treatment of Individuals at Risk of Pressure Ulcer Development or Skin Damage

- Interventions must be in place to support in educating patients, staff and carers regarding pressure ulcer prevention and skin damage.
- Individuals must be supported to be involved in their care and treatment.
- Within healthcare settings a holistic health needs assessment must be carried out.
- A pressure ulcer risk assessment must be completed and reassessed accordingly as the individual’s condition changes.
- The documentation must reflect the individual’s holistic health and social care needs; it must demonstrate implementation of care plans, risk assessments, equipment provision and referral to appropriate specialist teams / agencies.
- The care plans must be regularly reviewed according to changing needs and risk assessments re-evaluated and must incorporate the principles of prevention (SSKIN) listed above.
• Pressure ulcer assessment must be documented using the NPUAP / EPUAP classification system. (appendix 1)

• Appropriate advice has been sought from the appropriate practitioner e.g. Nurse/Tissue Viability Nurse/GP for care of patients with complex wounds and complex pressure ulcers at grade 3 and 4.

• The cause of the pressure ulcer must be identified e.g. Seating, footstools, mattress, positioning etc. and appropriate actions implemented to reduce damage and encourage healing.

• For patients non-concordant with the plan of care, e.g. where the individual refuses to adhere to prevention strategies in spite of education of the consequences of non-adherence” or due to lack of capacity to understand risks and consequences of not complying with agreed nursing /medical interventions , then a plan to reduce risk must be in place and reviewed regularly.

Mental Capacity Act Implementation

• Have the principles of the Mental Capacity Act 2005 been followed and capacity assumed unless proven otherwise?

• Does the individual have mental capacity to consent to their care and treatment plan?

• If there is reason to doubt the individual’s capacity for decision specific treatment, if so then mental capacity assessment must be assessed and documented?

• If the individual is found to lack capacity on the decision specific treatment need, then best interest process must be initiated with appropriate consultation with professionals/ family and IMCA where appropriate.

• Have best interest processes being followed, in line with the Mental Capacity Act requirements?

Points for consideration for the identification of safeguarding concerns where individuals have developed pressure ulcers or skin damage

• Is the care plan appropriate to meet the individual’s needs? If not this could be an omission of care

• Have risk assessments been reviewed to reflect changing needs? If not this could be an omission of care

• Has the individual been offered referral on to appropriate health agencies as their health needs indicate? If not this could be an omission of care
Has the individual been referred to their GP/Practice Nurse/Community Nurse/Tissue Viability Specialist? **If not this could be an omission of care**

Is practice in line with the Mental Capacity Act requirements? **If not this could be an omission of care**

Pressure ulcers at grade 3 and above must be alerted to the safeguarding enquiry team following the Lancashire Safeguarding Adults Board policy.

A decision will be made by the Multi Agency Safeguarding Hub if this meets the threshold for a safeguarding enquiry.

Where a pressure ulcer has developed due to an omission of care it must be reported to the local authority safeguarding enquiry team. Medical / nursing intervention must be sought as appropriate.

In instances where the alert is stepped up to a safeguarding enquiry and the provider is asked to investigate internally, their findings must be shared with the safeguarding enquiry team which will inform the safeguarding outcome and lessons learnt.

Under the principles of the Mental Capacity Act, If the individual has been assessed as lacking capacity for care and treatment relating to pressure ulcer management and they have developed preventable pressure ulcers at stage 3 and or 4 , then refer to safeguarding; the alerter must provide as much background information as possible to support the safeguarding enquiry process. The referrer must ensure that the individual has had access to appropriate nursing/medical intervention.

If there is a pattern, theme or trend identified which requires further enquiry into clinical practice issues then refer to the safeguarding enquiry team

Consideration must be given to the development of skin damage which is part of a pattern and or where there have been similar incidents involving the individual or others then refer to the safeguarding enquiry team.

**Responsibilities of Commissioners**

Commissioners have responsibility to:

- Ensure that all services which they commission meet nationally identified quality standards which are managed through the contracting and quality process.
- To monitor and seek assurance that providers are learning from incidents and actively minimising the risk of them happening again.
- Ensure that high quality services are commissioned with a focus on safeguarding vulnerable adults.
- Safeguard patients as required by professional regulators, service regulators and supported in law.
• Identify and manage safeguarding concerns appropriately.
• Support provider organisations to contribute to the safeguarding process.
• Seek assurance that services understand their safeguarding activity to enable accountability and ownership of learning and improvement.

Responsibilities of Providers

All provider services must ensure that:
• Safeguarding adults is an integral part of patient care.
• Safeguarding concerns are identified, reported and managed appropriately
• Practitioners are supported by their organisations to contribute to the safeguarding process.
• They understand safeguarding activity and lessons learnt, to enable accountability and ownership of learning and improvement.
• Individuals are consulted regarding the safeguarding process.
• Individual’s wishes feelings and beliefs are recorded.
• Information is shared with consent where appropriate, where possible, respecting the wishes of those who do not consent to share confidential information. Information can be shared without consent if, it is judged that lack of consent can be overridden in the public interest.
• Safeguarding alerts are raised where there are concerns regarding the best interests of the individual.
• As part of the registration requirements arising from the Health and Social Care Act 2008, provider organisations are required to notify the Care Quality Commission (CQC) about events that indicate or may indicate risks to on-going compliance.
• The registered person of the service provider is required to notify the CQC without delay of incidents which occur whilst services are being provided in the carrying out of a regulated activity. These include, any abuse or allegation of abuse in relation to a service user; any incident which is reported to, or investigated by, the police; and any injuries to the service user.

Responsibilities of Care Quality Commission

• The CQC key lines of enquiry inspection (KLOE) methodology requires services to demonstrate that they are safe, effective, caring, responsive and well led.
• Arrangements must be in place for continually reviewing safeguarding concerns, incidents and pressure ulcers to ensure themes are identified and any necessary action is taken.
• Information regarding concerns received about the quality of care must be investigated thoroughly and services must be able to demonstrate the difference that this has made to how care support and treatment is delivered.

• CQC registration requirements include the submission of relevant notifications and that any other legal obligations are met.

Individuals who use health and social care services must be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

Organisational Responsibilities of providers on an NHS Standard Contract

The National Framework for Reporting and learning from serious incidents requiring investigation provides guidelines to ensure that all incidents are reported to the relevant bodies to ensure full investigation (including independent investigations) and learning from significant events. Category 3 / 4 pressure ulceration is considered as a serious incident and must be reported to ensure a full investigation and lessons learnt. For further information please refer to the Commissioning Support Unit Guidance for the reporting of patient safety incidents in Care Homes and Independent Sector Mental Health Providers.

Prevention and Treatment of pressure ulcers (NICE, 2014) http://www.nice.org.uk/guidance/cg179/resources/guidance-pressure-ulcers-prevention-and-management-of-pressure-ulcers-pdf provides guidance for the use of all health professionals, regardless of clinical discipline, who are involved in the care of individuals who are at risk of developing pressure ulcers, or those with an existing pressure ulcer. The guidance is intended to apply to all clinical settings, including hospitals, rehabilitation care, long term care, assisted living at home, and unless specifically stated, can be considered appropriate for all individuals, regardless of their diagnosis or other health care needs. Additional support for care and treatment and classification of pressure ulcers category 1-4 can be found at http://www.epuap.org/wp-content/uploads/2010/10/NPUAP-EPUAP-PPPIA-Quick-Reference-Guide-2014-DIGITAL.pdf

Organisations must also refer to their individual policies and procedures.
LCFT Safeguarding Pressure Ulcer Reporting Process

Identification of Pressure Ulcer Grade 2 and above including un-stageable

**Grade 2**
- Complete a Datix
- Managed by reporting team
- Discuss with Line Manager
- Document within records

**Grade 3 & 4**
- Make a Safeguarding Alert to the Local Authority
- Complete a Datix
- Inform Line Manager
- Document within records

Safeguarding Alert to be considered if recurrent themes in same care setting or other identified concerns

**Safeguarding Enquiry Numbers**

**Lancashire County Council**
- 0300 123 672 (24 Hours)

**Blackburn with Darwen**
- 01254 585949
- 01254 587547 (Emergency Duty Team)

**Blackpool**
- 01253 477592
- 01253 477600 (Emergency Duty Team)

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Reporting Process Map for Pressure Ulcers

1. LCC Safeguarding Enquiry Team
2. Care Quality Commission (CQC)

For patients under a health contract, report provider acquired pressure ulcers grade 3 and above to Commissioning Support Unit (CSU).

For STEIS reported incidents the CCG will request a Route Cause Analysis report.

NHS Acute and Community Providers

Report all grade 3 and 4 pressure ulcers to LCC Safeguarding Enquiry Team.

Non provider acquired Grade 3 & 4 pressure ulcers report to appropriate commissioner and LCC Safeguarding Enquiry Team if evidence of poor care or neglect.

Provider acquired Grade 3 & 4 pressure ulcer occurrences must be reported to CQC.

For STEIS reported incidents follow governance process for internal investigation and completion of a Route Cause Analysis.

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Appendix 1
Pressure Ulcer Advisory Guidelines.
This is taken from the Prevention and Treatment of Pressure Ulcers: Quick Reference Guide 2014

International NPUAP/EPUAP Pressure Ulcer Classification System
A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

Category/Stage I: 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/Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” individuals (a heralding sign of risk).

Category/Stage 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/Stage must not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
*Bruising indicates suspected
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 tunneling. 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 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 on some parts of the wound bed. Often include undermining and tunneling. 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 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 possible. Exposed bone/tendon is visible or directly palpable.
Unstageable: 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/Stage, 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.
Reference


Department of Health (March 2011) *Adult Safeguarding: The Role of Health Services* Department of Health, London

HM Government (2014) *The Care Act*

Lancashire Safeguarding Adults Board *Policies, Procedures and Practice Guidance*


Acknowledgement is given to the task and finish group members in the development of this tool:

Lead Nurse Safeguarding Adults and MCA
Chorley South Ribble, Greater Preston and West Lancs Clinical Commissioning Groups

Lead Practitioner Tissue Viability and Treatment Room Services - Lancashire Care Foundation Trust (LCFT)
Tissue Viability Nurse Lancashire
Teaching Hospitals Trust

Named Nurse Safeguarding Adults
LCFT

Safeguarding Manger
Fylde and Wyre and North Lancashire Clinical Commissioning Groups

Representative
Lancashire Care Association

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Inspector
*Care Quality Commission (CQC)*
Advanced Practitioner
*Lancashire County Council Safeguarding Enquiry Team*