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# **Adult Safeguarding Team Standard Operating Procedure Reporting Avoidable Pressure Damage to Local Authority Safeguarding Teams**

## **Summary of document:**

A procedure outlining the role of the Adult Safeguarding Team in reporting avoidable pressure damage which has occurred in the Acute Hospitals to the relevant Local Authorities.

## **Scope:**

This procedure is intended for use by HDdUHB Adult Safeguarding Team and Carmarthenshire, Ceredigion and Pembrokeshire Local Authorities. It is for information only for acute hospital sites.

## **To be read in conjunction with:**

Prevention and Management of Pressure Ulcer Policy

Wales Safeguarding Procedures 2019

Social Services and Well- Being (Wales) Act 2014

Information Sharing Protocol for the Safeguarding of Children, YP and Adults within West Wales procedure

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## Scope

This procedure outlines the recording and reporting by the Hywel Dda University Health Board (HDdUHB) Adult Safeguarding Team (AST) of pressure damage cases discussed at scrutiny meetings, in particular those deemed avoidable within the four Acute Hospitals in HDdUHB. This will ensure that appropriate reporting can be made to the relevant Local Authority in accordance with the Memorandum of Understanding as agreed with the CWMPAS Regional Safeguarding Board which will be replaced by this procedure.

## Aim

The aim of this document is to describe the process and responsibility of the HDdUHB AST in collating and reporting avoidable pressure for reporting to the relevant Local Authority.

## Objectives

- Provide an overview of the role of the AST in the pressure damage scrutiny process
- Outline the process by which information is collated and recorded
- Outline the process by which avoidable pressure damage is reported to the Local Authority.

## Procedure

- All occurrences of pressure damage should be reported by Health Board staff via the DATIX incident reporting system. The incidents are then investigated in line with the All Wales Pressure Ulcer Reporting and Investigation guidance as indicated in the HDdUHB Prevention and Management of Pressure Ulcer Policy. The investigation is completed by the relevant service using the All Wales Review Tool for Pressure Damage investigation (contained in the guidance and is part of the DATIX record) which enables the examination of evidence relating to risk assessments, equipment, skin checks, reviews and organisational factors, and highlighting learning needs and remedial actions.
- Avoidable pressure damage is defined as:  
*“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; plan and implement interventions that are consistent with the person’s needs and goals and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.*” (Department of Health/ National Patient Safety Agency, 2010 quoted in the All Wales guidance)
- Avoidable pressure damage may indicate there has been neglect in care and as such requires reporting to the relevant Local Authority in accordance with the statutory obligations under the Social Services and Wellbeing (Wales) Act 2014 (SSWBA). However, HDdUHB has agreed with the Local Authorities to facilitate

submitting avoidable pressure damage data without the need to submit individual Adult Safeguarding Report Forms for each individual case.

- The HDdUHB Pressure Ulcer Reporting and Investigation policy indicates that all identified incidents of pressure damage should be screened for safeguarding – this screening is captured within the All Wales Pressure Damage Investigation Tool. DATIX incidents that are flagged to the AST (when ‘yes’ or ‘don’t know’ is selected by the reporter to the safeguarding question) should be reviewed by AST practitioners. Whilst reviewing the narrative of the flagged incidents, the AST practitioner needs to consider whether there are any exceptional circumstances that would suggest the need for immediate safeguarding screening rather than waiting for review within the scrutiny process. If this is the case, then the AST practitioner will send communication from within the DATIX record to the service lead to request completion of the safeguarding screening tool
- DATIX Excel monthly reports for pressure damage are sent to the AST from the DATIX team, these list all the pressure damage incidents that have been reported for discussion at forthcoming scrutiny meetings.

For acute hospitals, pressure damage scrutiny meetings are held at least monthly for each site and the AST are invited to attend. Prior to the scrutiny meeting, the service will have completed the All Wales Review Tool for Pressure Damage Investigation; at the meeting the findings are presented and discussed, and the outcome of unavoidable/avoidable agreed.

- The AST member along with the other panel members should consider the information presented with particular attention to the four questions listed below in Section 6 of the review tool, to identify if the pressure damage was avoidable, also if any potential safeguarding issues that may require individual Safeguarding Report Forms to be sent to the Local Authority retrospectively. Each case of avoidable pressure damage should trigger an action plan that the service should keep a record of and keep track that actions are completed.

#### Scrutiny Outcome questions:

1. Were the individual’s pressure ulcer risk factors identified and regularly reviewed; and skin damage reported as per local policy and guidance?
2. Were preventative interventions, consistent with the individual’s needs/goals and recognised standards of practice planned & implemented?
3. Was the effectiveness of the preventative interventions reliably evaluated & monitored?
4. Were interventions revised & acted on when there was a change to the individual’s clinical or skin condition?

If ‘NO’ is answered to any of the above, the pressure ulcer is considered avoidable.

- In the event that a member of the AST is not present at the scrutiny meeting, outcomes from the meeting should be sent by the Chair of the scrutiny panel or a nominated representative to the AST.

The AST will collate the data relating to all the avoidable pressure damage in an Excel spreadsheet. This lists the DATIX reference number, the acute hospital site and ward where the pressure damage occurred; date of incident and date scrutiny meeting held; location of pressure damage on the body and the grade. The spreadsheet is sent to the relevant Local Authority Adult Safeguarding Leads, if appropriate, a short narrative will also be included. This is completed on a quarterly basis.

- A quarterly report will also be produced for submission to multi-agency Local Operational Groups (LOGs); this incorporates a chart of each hospital's data for each quarter for comparison together with narrative to describe and interpret the data.
- For assurance of the process embedded in HDdUHB and agreed with Local Authority partners, the Local Authorities can request an audit to be carried out in regard to cases of reported avoidable pressure damage. Previous audits have consisted of each Local Authority choosing two DATIX numbers from the previous year; Carmarthenshire have included two each from Prince Philip Hospital and Glangwili General Hospital.
- DATIX numbers and requests for information are to be sent by the AST to the relevant Acute Hospital Head of Nursing requesting that the service provide evidence of discussion at scrutiny meetings, actions plans and evidence of implementation of action plans related to the identified cases. A report is then produced and fed back to the Heads of Nursing of the Acute Hospitals and presented at the Acute Service Delivery Group meeting. Following this, it is sent to the Local Authority Adult Safeguarding Leads. At the conclusion of the process, a report would also be shared with the LOGs.
- All data pertaining to avoidable pressure damage is stored by the AST in the Adult Safeguarding shared drive in a folder labelled 'Pressure Damage'.

## References

All Wales Pressure Ulcer Reporting and Investigation – All Wales Guidance 2018

Available at:

<https://www.gov.wales/sites/default/files/publications/2019-07/welsh-health-circular-on-revised-pressure-ulcer-reporting-including-the-reporting-of-serious-incidents.pdf>

Social Services and Well-being (Wales) Act 2014

Available at:

<https://www.legislation.gov.uk/anaw/2014/4/contents>

Wales Safeguarding Procedures 2019

Available at:

<https://www.safeguarding.wales/en/>