NHS
Norfolk and Waveney
Integrated Care Board

Safeguarding Concern Assessment Guidance for RCA feedback from LA to nwicb.safeguardingadultsnorfolk@nhs.net

Acknowledgment is given to a Task and Finish group, working on behalf of the Cambridgeshire and Peterborough Safeguarding Adults Board July 2019, who developed the following guidance to support the Pressure Ulcer Protocol Published by Department of Health & Social Care in January 2018 and aim to assist practitioners understand the interface between the protocol and a safeguarding enquiry.

It is vital that any consideration of Pressure Ulcers being linked to safeguarding includes a wider consideration of whether other concerns over abuse and/or neglect are present for the Adult at Risk.

Pressure Ulcers can be a safeguarding concern. This is more likely where the ulcer is avoidable and serious in its impact. They are frequently associated with other safeguarding concerns, such as neglect and self-neglect. These can include poor diet, inadequate care, and inappropriate physical handling. Pressure Ulcers can be the result of appropriate equipment not being accepted or used, which could be Domestic Abuse.

Professional and medical information on the identification, assessment and treatment of Pressure Ulcers can be found at:

- NHS Guidance
- NICE Guidance
- Prevention and Treatment of Pressure Ulcers: Quick Reference Guide

Information for the wider public is available at:

https://www.nice.org.uk/guidance/cg179/ifp/chapter/What-is-a-pressure-ulcer

To assist in deciding whether an ulcer should be considered a safeguarding concern, there is a national Safeguarding Protocol that can be found at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675192/CSW_ulcer_protocol_guidance.pdf

[1] Reference: Whiting NL (2009) Skin assessment of patients at risk of pressure ulcers. Nursing Standard vol 24 no. 10 pages 40 – 44

An Adult Safeguarding Decision Guide assessment for service users with pressure ulcers should be completed by a qualified member of staff who is a practising Registered Nurse (RN), with experience in wound management and not directly involved in the provision of care to the service user.

This does not have to be a Tissue Viability Nurse. The adult safeguarding decision guide should be completed immediately or within 48 hours of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension should be recorded.

The tool is to be used to support the decision as to whether there should be a section 42 enquiry will be taken by the local authority, informed by a clinical view.

The outcome of the Adult Safeguarding Decision Guide assessment should be documented on the Adult Safeguarding Decision Guide-(Appendix 1)

A summary of the decision should be recorded and shared with all agencies involved.

The local authority needs to decide/agree post completion of the internal investigation if a full multi-agency meeting or virtual (telephone) meeting needs to be convened to agree findings, decide on safeguarding outcome and any actions.

The safeguarding decision guide assessment considers six key questions:

The six questions shown below together indicate a safeguarding decision guide score. This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the pressure ulceration. It is not a tool to risk assess for the development of pressure damage.

The threshold for raising a concern is 15 or above. However, this should not replace professional judgement. The questions and scores are outlined below which provide the full decision-making tool and recording document.

1. Has the patient or service user's skin deteriorated to either category 3/4/unstageable or multiple sites of category 2 ulceration from healthy unbroken skin since the last opportunity to assess/visit?
2. Has there been a recent change in their clinical condition that could have contributed to skin damage? E.g., infection, pyrexia, anaemia, end of life care (Skin Changes at Life End), critical illness?
3. Was there a pressure ulcer risk assessment and reassessment with an appropriate pressure ulcer care plan in place and was this documented in line with the organisation's policy and guidance?
4. Is there a concern that the pressure ulcer developed because of the informal carer ignoring or preventing access to care or services?
5. Is the level of damage to skin inconsistent with the service user's risk status for pressure ulcer development? E.g., low risk –category/ grade 3 or 4 pressure ulcer?
6. Answer (a) if the individual has capacity to consent to every element of the care plan – Was the individual able to implement the care plan having received clear information regarding the risks of not doing so.

Answer (b) if the individual has been assessed as not having mental capacity to consent to any or some of the care plan - Was appropriate care undertaken in the individual's best interests, following the best interest's checklist in the Mental Capacity Act Code of Practice

(Supported by documentation, e.g., capacity, and best interest statements and record of care delivered)?

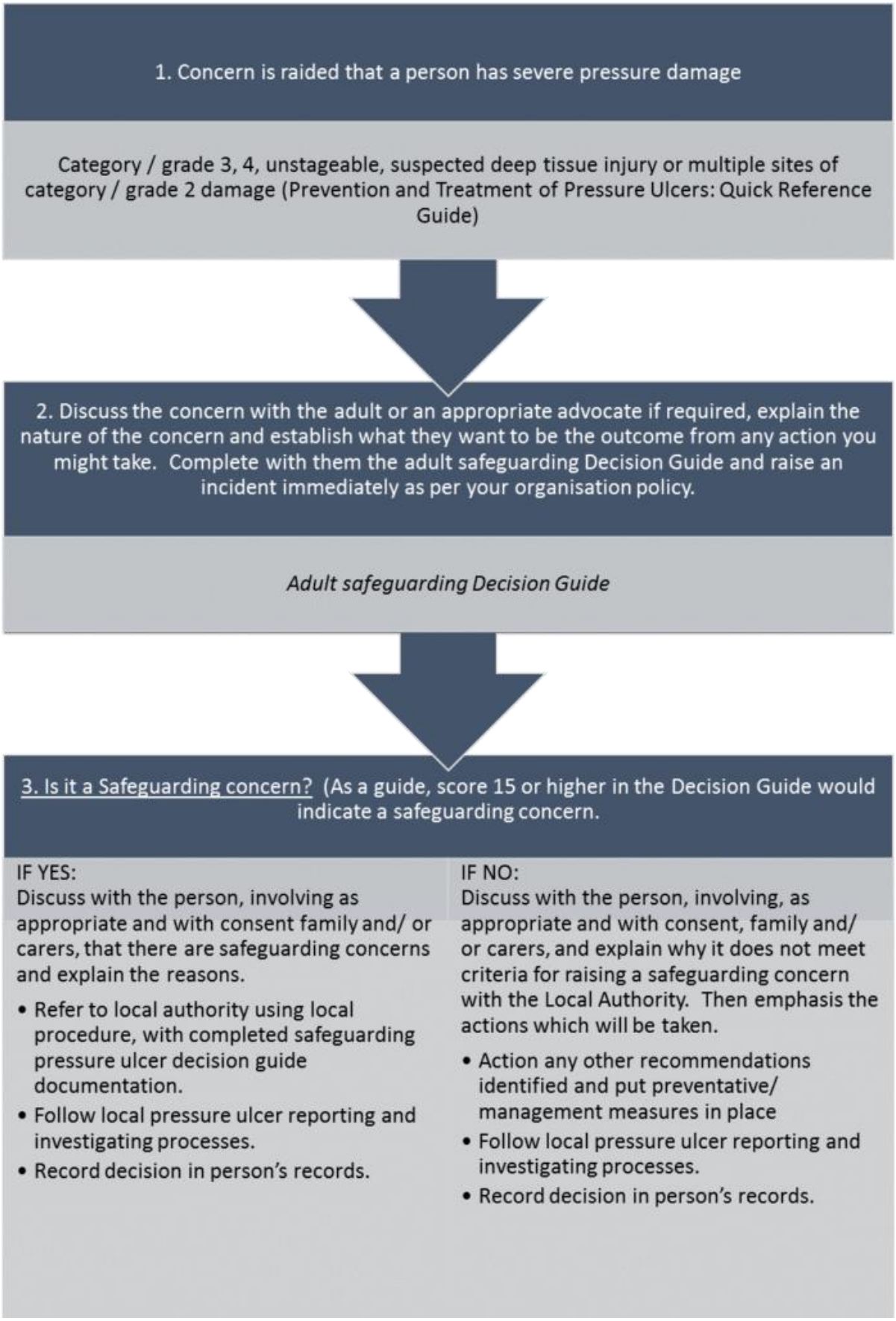
• Is there evidence that the person, or their representative, was involved with the care and support planning, and did they consent to the care plan?

• Is there evidence that this involvement was reviewed if care needs changed, and the current care plan would meet the needs of the person.

• Is there evidence that if the person was not consenting to the care plan that other remedial actions were considered to mitigate risk of harm.

• If at the point of the care plan being put in place it was identified that the person lacked capacity to consent to it, was the care plan lawfully put in place in their best interest?

Flow chart


1. Concern is raided that a person has severe pressure damage
Category / grade 3, 4, unstageable, suspected deep tissue injury or multiple sites of category / grade 2 damage (Prevention and Treatment of Pressure Ulcers: Quick Reference Guide)
2. Discuss the concern with the adult or an appropriate advocate if required, explain the nature of the concern and establish what they want to be the outcome from any action you might take. Complete with them the adult safeguarding Decision Guide and raise an incident immediately as per your organisation policy.
Adult safeguarding Decision Guide
3. Is it a Safeguarding concern? (As a guide, score 15 or higher in the Decision Guide would indicate a safeguarding concern.
IF YES:
Discuss with the person, involving as appropriate and with consent family and/ or carers, that there are safeguarding concerns and explain the reasons.
• Refer to local authority using local procedure, with completed safeguarding pressure ulcer decision guide documentation.
• Follow local pressure ulcer reporting and investigating processes.
• Record decision in person's records.
IF NO:
Discuss with the person, involving, as appropriate and with consent, family and/ or carers, and explain why it does not meet criteria for raising a safeguarding concern with the Local Authority. Then emphasis the actions which will be taken.
• Action any other recommendations identified and put preventative/ management measures in place
• Follow local pressure ulcer reporting and investigating processes.
• Record decision in person's records.

Appendix : Decision Process

1. Concern is raised that a person has severe pressure damage-Category/grade 3, 4, unstageable, suspected deep tissue injury or multiple sites of category/ grade 2 damage (EPUAP, 2014)

2. An incident is raised immediately with Safeguarding front door as per organisation policy.

Score 15 or higher? Concern for safeguarding

IF YES:

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.

- Local authority are informed via local procedure
- Follow local pressure ulcer reporting and investigating processes.
- Local authority liaises with careprovidernurses nwicb.qualityimprovementnurses@nhs.net and nwicb.safeguardingadultsnorfolk@nhs.net attaching the RCA for this incident and care provider team provide an overview using completed safeguarding pressure ulcer decision guide documentation with support from NWICB safeguarding team if escalated.
- Response sent back from Quality improvement nurses to MASH - Adult Safeguarding mashadultsafeguarding@norfolk.gov.uk cc in nwicb.safeguardingadultsnorfolk@nhs.net
- Local authority review response and record decision in person's records.

IF NO

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.

- Action any other recommendations identified and put preventative/ management measures in place.
- Follow local pressure ulcer reporting and investigating processes.
- Record decision in person's records.

Appendix: Adult Safeguarding Decision Guide for individuals with severe pressure ulcers

Q	Risk Category	Level of Concern	Score	Evidence
1	Has the patient's skin deteriorated to either grade 3/4/ unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/ visit	Yes e.g., record of blanching / non-blanching erythema /Grade 2 progressing to grade 2 or more	5	e.g., evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
		No	0	

		e.g., no previous skin integrity issues or no previous contact health or social care services		
2	Has there been a recent change, i.e., within days or hours, in their / clinical condition that could have contributed to skin damage? e.g., infection, pyrexia, anaemia, end of life care, critical illness	Change in condition contributing to skin damage	0	
		No change in condition that could contribute to skin damage	5	
3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance.	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patient's needs.	0	State date of assessment Risk tool used Score / Risk level
		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	What elements of care plan are in place
		No or incomplete risk assessment and/or care plan carried out	15	What elements would have been expected to be in place but were not
4	Is there a concern that the Pressure Ulcer developed because of the informal carer wilfully ignoring or preventing access to care or services	No/Not applicable	0	
		Yes	15	
5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g., low risk–Category/ grade 3 or 4 pressure ulcer	Skin damage less severe than patient's risk assessment suggests is proportional	0	
		Skin damage more severe than patient's	10	

		risk assessment suggests is proportional		
6	Answer (a) if your patient has capacity to consent to every element of the care plan. Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan.			
a	Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Patient has not followed care plan and local non concordance policies have been followed.	0	
		Patient followed some aspects of care plan but not all	3	
		Patient followed care plan or not given information to enable them to make an informed choice.	5	
b	Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice? (Supported by documentation, e.g., Capacity, and best interest statements and record of care delivered)	Documentation of care being undertaken in patient's best interests	0	
		No documentation of care being undertaken in patient's best interests	10	
	TOTAL SCORE			

If the score is 15 or over, discuss with the local authority (safeguarding) as determined by local procedures and reflecting the urgency of the situation. When the decision guide has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the persons notes.