Protocol for Determining Neglect in the Development of a Pressure Ulcer

Date of Implementation: **October 2012**
Date of Review: **October 2014**

National and Regional Context: This protocol is supported by the following legislation and guidance:

- No Secrets Guidance (DOH 2000)
- The Mental Capacity Act (2005)
- The Deprivation of Liberty Safeguards (2007)
- The Health & Social Care Act (2008)
- The Health Act (2009)
- Regional and national guidance for Social Services
- Clinical Guidelines for the Prevention and Treatment of Pressure Ulcers (The National Institute for Health and Clinical Excellence 2005)
- The European Pressure Ulcer Advisory Panel (EPUAP) and The National Pressure Ulcer Advisory Panel (NPUAP)
- Clinical Governance and Adult Safeguarding: An Integrated Process (DOH 2010)
- National Framework for Reporting and Learning from Serious Incidents requiring investigation (NHS National Patient Safety Agency 2010)
- Essential Standards of Quality and Safety – Section 20 Regulations of the Health & Social Care Act (DOH 2011) – Specifically Outcome 7
- Safeguarding Adults: The Role of Health Services (DOH 2011)
- The South West Quality Improvement Framework for the Prevention and Management of Pressure Ulcers (2012)
- Commission on Dignity in Care for Older People – Delivering Dignity Consultation (2012)
- Nursing and Midwifery Council – Standards and Code of Practice

Contents

1 Introduction

Pressure ulcers are costly in terms of both human suffering and the use of resources (EPUAP 2009). The one defining feature is that in the majority of cases pressure ulcers are preventable if simple measures are followed and so; not to prevent the preventable could constitute neglect (Hofman 2006)

It is estimated that just under half a million people in the UK will develop at least one pressure ulcer in any given year, usually affecting people with an underlying health condition. Within these statistics, around 1:20 people who are admitted to hospital with an acute illness will develop a pressure ulcer (NHS Choices Oct 2010)

A pressure ulcer is defined as 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 factors are associated with pressure ulcers; the significance of these factors is yet to be elucidated (EPUAP)

Pressure ulcers can occur in any individual but are more likely in high risk groups, such as the elderly, people who are obese, malnourished or who have continence problems as well as people with certain skin types and those with particular underlying conditions

Ulceration occurs when the skin and underlying tissues are compressed for a period of time, between the bone and the surface, on which the individual is sitting or lying. Blood cannot circulate causing a lack of oxygen and nutrients to the tissue cells. Furthermore, the lymphatic system cannot function properly and remove waste products

If the pressure continues, the cells die and the area of dead tissue that results is called pressure damage. The amount of time that this takes will vary, but may develop in as little as one hour in individuals at greatest risk

It is recognised however, that there are situations where the development of a pressure ulcer is unavoidable. The following guidance is taken from the NPSA (2010; *Defining avoidable and unavoidable pressure ulcers*)

'Unavoidable' means that the person receiving care developed a pressure ulcer even though the provider of the care 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 the prevention strategies in spite of education of the consequences of non-adherence'

Neglect, in the context of pressure ulcer management and adults at risk in this protocol will be defined as:

> The deliberate withholding or unintentional failure to provide appropriate care and support, has resulted in, or is highly likely to result in (when considering other adults at risk in the same situation), a preventable pressure ulcer.

2 Purpose

The overall purpose of this protocol is to protect adults at risk by providing a framework to guide health and social care agencies on whether safeguarding procedures need to be instigated when concerns have been raised that a pressure ulcer may have developed as a result of neglect. Whilst Category 3 and 4 pressure ulcers will be routinely scoped to determine whether safeguarding procedures are indicated, any category of ulcer **(EPUAP 2009)** should be considered as possible neglect (see Appendix 1 for category classification). This protocol will enable staff to identify if it is likely the pressure ulcer was caused as a result of neglect. It will provide a focus on thresholds for referral through the Safeguarding Adults process. It is important that this protocol dovetails into and is embedded within each organisations own pressure ulcer prevention and management policies and guidance.

No Secrets (2000) defines a vulnerable adult as one "who is or may be in need of community care services by reason of mental or other disability, age or illness; **and** who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

Adults 'who may be eligible for community care services' are those whose independence and wellbeing would be at risk if they did not receive appropriate health and social care support. They include adults with physical, sensory and mental impairments and learning disabilities, whether present from birth or due to advancing age, chronic illness or accident. They also include family and friends who provide personal assistance and care to adults on an unpaid basis. They are not a self-defined community, but a group that has been created by social policy.

This definition has been adopted within the B&NES Multi-Agency Safeguarding Adult Policy and Procedures (2010). The term 'vulnerable adult' has now been superseded by the term 'adults at risk' following the Law Commission Report (2011)

3 Scope

This protocol applies to all Health and Social Care staff working in Bath & North East Somerset with adults at risk over the age of 18 who develop a pressure ulcer or are at risk of developing a pressure ulcer. This guidance should not replace the need to read and refer to the following documents:

- B&NES Multi-Agency Safeguarding Adults Policy and Procedures (2010)
- B&NES Multi-Agency Safeguarding Adults Consent Policy (2011)

- B&NES Multi-Agency Safeguarding Adults Information Sharing Principles (2010)
- B&NES Multi-Agency Safeguarding Adults Protocol on Self-Neglect (2011)

3.1 Partnership organisations should also have the following policies and procedures in place to support practice

- Consent Policy
- Information sharing agreement
- Incident reporting and Serious Incident Reporting Policy and Procedures
- Whistle Blowing Policy
- Dignity in Care Policy
- With Holding Care Policy
- Pressure Ulcer Prevention and Management Guidelines
- Safeguarding Adults from Abuse Policy and Procedures
- Assessment of Mental Capacity and Determining Best Interest Guidance
- Guidance on Self-Neglect

4 Mental Capacity

The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect adults at risk who are not able to make their own decisions. There is a presumption in English Law that everyone has mental capacity until the contrary is proved; this applies equally in civil as well as in criminal cases. Each organisation should have Policies and Procedures in place to support staff in the application of the MCA. The MCA assumes people have the right to make their own choices (self-determination) in relation to safety from abuse and neglect – except where the rights of others would be compromised. All people should be supported to access information about options that are open to them. A person's consent must be given freely and unconditionally (staff should refer to their own organisational Consent Policies). A person acting under duress is not acting freely. All actions should be in accordance with the Mental Capacity Act (2005).

In the case of a person who is deemed to lack the mental capacity to make a particular decision, it is essential that everything that is done for or on behalf of that person be in their best interests. The Act provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interest. Those involved in the care of the individual gain a right to be consulted. Where the person has no advocate a referral can be made for an Independent Mental Capacity Advocate.

The most relevant aspect of mental capacity is that of understanding, and making decisions about safety from abuse and neglect. The test essentially is whether a person is capable of understanding what s/he does when its nature and effect is explained. Making this decision includes having information about what is taking place, the harm that it may cause, and the options that are open to stop the abuse or neglect, or reduce harm. It includes weighing up that information and communicating the decision.

Everyone has a right to follow a course of action that others judge to be unwise or eccentric, including one that may lead to them being abused. Where a person chooses to live with a risk of abuse the safeguarding plan should include access to services that help minimise the risk.

For some adults their cognitive impairments mean they need proactive support to understand that they have choice to live a safer life, to understand the options open to them; to choose which, if any, services they want to access in order to do so.

For other adults, even with support, their cognitive impairments may mean they do not have the mental capacity to make decisions. The capacity of some adults may fluctuate, and they may not be able to make a decision about how to pursue their safety at the time it is needed. In such situations staff must take positive action to ensure that such decisions are made on the persons' behalf (Best Interest Assessment). Staff should respond as described in the persons Advanced Directive should they have one.

Section 5 of the Mental Capacity Act 2005, clarifies that, where a person is providing care or treatment for someone who lacks capacity, then the person can provide the care without incurring legal liability. However, the key will be proper assessment of capacity and best interests. This will cover actions that would otherwise result in a civil wrong doing or crime if someone has to interfere with the person's body (or property) in the ordinary course of caring.

However, the Act (Section 44) also introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. Harm can be inflicted by individuals, groups, agencies or the state. In determining neglect, there is a need to first identify the significant harm imposed directly or indirectly and the nature and extent of the ill-treatment or neglect. Evidentially, the following information should be measured when considering if an offence has been committed under the Mental Capacity Act:

- Has a deliberate act of neglect or harm taken place
- What level of culpability does the individual, group (etc) have
- What is the level of harm caused

- What level of neglect has taken place to cause harm (this includes the failure to provide care)
- Has the individual actively carried out ill-treatment or neglect
- Are there witnesses to the offence

If a criminal offence is suspected, it is the role of the Police to investigate. The case should also be referred down the Safeguarding Adult route.

Within the Safeguarding Adult Policy and joint working arrangements, partnership agencies may be required to work jointly with the Police during the investigation and/or assist in information gathering.

The wishes of a person with Mental Capacity should normally be respected. However, the health and social care staff must act to uphold the human rights of all citizens and where others are at risk this duty will take precedence.

5 Current tools used to identify "at risk" individuals and categorise the severity of pressure ulcers

There are various assessment tools and guidelines which assist with the identification and management of those people at risk of developing pressure ulcers.

- All organisations should have their own Pressure Ulcer Prevention and Management Guidelines
- All organisations should have their own pressure ulcer risk assessment tool e.g., Waterlow Risk Assessment; Pressure Ulcer Risk Assessment (PURA)
- Categorisation of ulcers should be recorded using the European Pressure Ulcer Classification System (2009) as recommended by NICE 2005 (see Appendix 1)
- The Malnutrition Universal Screening Tool (MUST)

Health and Social Care professionals must be able to evidence their attendance at Pressure Ulcer Prevention and Management and Wound Care training appropriate to the requirement of their role. They must also be able to evidence competence and continued professional development through appraisals and supervision

6 Documentation

Where health and social care professionals have responsibility for the care of individuals in hospital and/or the community, appropriate documentation should be completed assessing skin integrity and pressure ulcer risk when first seen and on an on-going basis where a risk has been identified. The assessment and plan of care should be documented and re-evaluated to reflect changes in the individual's

condition. Good practice should include a nutritional assessment and a 24 hour positioning plan. Appropriate pressure relieving equipment should be provided and documented

If there is a pressure ulcer present a wound assessment should also be undertaken. This will include:

- Site and category of each pressure ulcer using the EUPAP (2009) classification system
- Wound dimensions (length/width/depth/undermining)
- Type of tissue in wound bed
- Wound exudate levels and type
- Signs of wound infection
- Condition of skin surrounding ulcers
- Documentation of treatment plan
- Appropriate use of dressings with rationale for choice
- Evidence of evaluation and reassessment

Where an adult at risk in the care of Community Services or a Care Home requires transfer into another health or social care establishment (for example: a care home or hospital), **staff will be expected to complete in full a "condition of skin" transfer form** (see Appendix 2) providing details of any marks on the skin or pressure ulcers present, risk management details, treatment and interventions up until the point of transfer and assessment details of the individuals mental capacity.

This will assist the receiving health or social care establishment in their own assessment and gathering of information and help to prevent inappropriate referrals into the Safeguarding Adult process.

Where an adult at risk has mental capacity and chooses not to engage/accept interventions (treatment/care and/or appropriate pressure relieving equipment) with regard to either the risk of developing pressure ulcers or the care of existing pressure ulcers, a formal mental capacity assessment must be carried out and documented in the individual's notes.

During this assessment the individual should be fully informed of the risks associated with their choice and the implications that this could have on their health. The professional undertaking this assessment must escalate these concerns within their management structure and seek further support and advice.

In conjunction with this, a risk assessment must also be completed (in line with the organisational Risk Management Policy) that fully documents the risks and implications of not engaging with recommended care and treatment. This assessment may be key in helping to determine whether neglect has occurred and will need to be regularly reviewed. Consideration should be given to implementing the B&NES Safeguarding Adults Multi-Agency Self-Neglect Guidance if this is indicated

7 Five Steps to take to determine if a pressure ulcer is due to neglect of an adult at risk

7.1 Step One. Assess if there is a problem

Where tissue viability is a concern and the adult at risk lives in their own home or a Care Home (providing social care/residential), concerns may first be identified by a carer (either formal or informal), who can refer to an appropriate health professional (e.g. GP, Practice Nurse or Community Nurse) for assessment and treatment. The health community can provide information to informal carers on how to identify possible skin care problems

Hospitals and Care Homes providing nursing care employ registered nurses with the relevant skills and knowledge to undertake assessment of the risk of pressure ulcer development and manage treatment. Care Homes providing nursing care may sometimes require the additional support of more specialist intervention such as a tissue viability nurse to manage care and treatment.

Where Health or Social Care staff identify or receive concerns in respect of a pressure ulcer they must ensure that an assessment of the individual and their care takes place by a health care professional – a registered nurse and/or a tissue viability nurse (depending upon the complexity of the wound) who has the appropriate skills and knowledge to undertake this assessment.

The health care professional undertaking the assessment will consider the adult at risk, establish how their care has been delivered and review information already gathered to assess if all reasonable steps have been taken to prevent the pressure ulcer. The care that was given should be assessed against available local and national guidance. A second opinion should be sought if necessary.

Referral into the Safeguarding Adult process and the instigation of a discussion and/or strategy meeting is required when there is a high risk of serious harm being caused by acts or omissions to care in relation to pressure ulcer development and management which could reasonably have been avoided.

It is important to note that harm does not need to be deliberate. Some neglect is not deliberate. It is not the intent that needs to be considered but the harm that has resulted from the act or omission and which should trigger the multi – agency safeguarding procedures.

7.2 Step Two. Consider these three questions (see Appendix 4):

Question 1) Is the adult at risk?

Abuse is a violation of an individual's human and civil rights by any other person or persons. It exists where the vulnerable person suffers significant harm or is exposed to significant risk.

In this context the definition of 'significant' will require a professional judgement. Consider the definition of vulnerability (adult at risk) contained in the B&NES Multi-Agency Safeguarding Adults Policy and Procedures (2010)

Question 2) Is there evidence of neglect?

Not all pressure ulcers in adults at risk are the result of neglect.

Relevant factors to consider:

- The individual's compliance/behaviour that might impact on appropriate care being given.
- Other co-morbidities such as chronic disease and palliative care
- Capacity to consent or decline treatment.
- Health and Social Care involvement
- Carer involvement.

Neglect is ignoring or withholding physical or medical care needs and includes a failure to provide appropriate food, shelter, heating, clothing, medical care, hygiene, personal care, inappropriate use of medication and over medication.

In the case of pressure ulcer development, **neglect** is the deliberate withholding **OR** unintentional failure to provide appropriate **OR** adequate care and support, that has resulted in, or is highly likely to result in (when considering other adults at risk in the same situation), a preventable pressure ulcer.

Question 3) Are there concerns that all reasonable steps have not been taken to prevent the pressure ulcer?

Review the information already gathered about the adult at risk, and then consider the pressure ulcer history.

Circumstances of neglect should be considered where pressure ulcers of any category are present. If there are concerns about neglect an assessment of the care provided using the information available should be undertaken.

A judgement may be required about whether an act or an act of omission has caused significant harm. Determining whether or not abuse of an adult at risk has taken place is not always a straightforward matter, particularly when there are issues of neglect.

A second opinion should be sought if considered necessary, for example: a Tissue Viability Nurse Specialist or Safeguarding Lead

The health care professional undertaking the assessment should review the standard and detail of documentation and evidence of the care regime against the criteria below:

Patient history:

- Whether rapid onset and deterioration to a severe ulcer
- Patient compliance and behaviour
- Mental Capacity to consent to treatment and interventions
- Whether extensive damage to a low risk patient

Co-morbidity:

- Medical history
- Chronic disease
- Palliative care
- Mental health issues

Indicators of neglect:

Is the person's physical appearance poor?

Consider:

- General appearance.
- Hygiene.
- Dirty nails.
- Poor oral hygiene.
- Soiled or wet clothing.

Is there evidence of poor quality care?

Consider:

- Standard of assessment and the use of relevant policy and procedures to support care plan.
- Evidence of identification and management of risk factors for pressure ulcer development.
- Whether appropriate equipment has been provided
- Evidence of implementation of plan of care
- Evidence that regular reassessment of care plan has been carried out and implemented.
- Evidence of continence management plan in place.
- Nutritional assessment and implementation of associated care plan (the use of the Malnutrition Universal Screening Tool is recognised as good practice). Evidence of intake monitoring, fluid balance, regular weighing
- Evidence of risk management.

- Evidence of appropriate preventative and treatment regime.
- Recurrent pressure ulcers.
- Evidence of appropriate wound assessment and dressing selection (with rationale for choice).
- Evidence of appropriate use of medication analgesia and/or sedation.
  - Note use of sedation if patient is immobile for extended periods
  - If pain has been assessed and is being managed

Key questions to ask that apply to all settings.

- Where no monitoring has taken place prior to the development of a pressure ulcer, should the illness, behaviour or disability of the adult at risk have reasonably required the monitoring/treatment of the skin condition?

- If the monitoring/treatment of the skin condition was then refused by the adult at risk/family was it reasonable for advice to be sought?

  The adult at risks consent to monitoring should always be sought and documented, but if the person lacks mental capacity to make a decision regarding this, then a best interest assessment should be carried out under the Mental Capacity Act 2005 and an appropriate decision made on behalf of the individual. Where there is no representation for the vulnerable adult who lacks mental capacity, a referral should be made to the IMCA service (Independent Mental Capacity Advisor). The family have no right to refuse treatment or monitoring.

  If a person who lacks mental capacity has an Advanced Directive, staff should respond accordingly to the pre-determined wishes of the individual.

- If monitoring/treatment of the skin condition was agreed, was the frequency of the monitoring/treatment appropriate for the condition as presented at the time?

- Would monitoring have shown changes in presentation of the skin (e.g. Persistent change in colour, temperature of skin etc.) that should have triggered the need for intervention or the seeking of more expert assistance that would have prevented serious harm or its high likelihood?

- Was appropriate expert advice sought? If so did this result in a plan appropriate to address the pressure needs of the adult at risk?

- Was the care plan adhered to and evaluated appropriately? Was the equipment provided in a timely manner and used appropriately?

If the answer to all three questions within Step Two is yes, then a safeguarding adult alert should be made under the B&NES Multi-Agency Safeguarding Adult Procedures to Sirona Care & Health by contacting the following telephone numbers:

From Monday to Friday – 01225 39600

Out of Hours via the Emergency Duty Team – 01454 615 165

7.3 Step Three – referring into Safeguarding Adult Procedures

The B&NES Multi-Agency Safeguarding Adults Policy & Procedures 2010 places a duty of care on all health and social care staff, statutory and independent sectors, to report allegations, concerns and suspicions of abuse. It is the areas of neglect where the greatest uncertainty often arises with respect to possible abuse. The Safeguarding Procedures are designed to identify whether or not there is abuse within a multi-agency arena – staff do not need to make such judgements on their own.

All health and social care staff are expected to be familiar with this Policy and Procedure for identifying and reporting concerns of abuse. Organisations may also have their own formal internal procedures in place.

If the alleged abuse/neglect is discovered or suspected, it needs to be made clear that such information may need to be shared with other agencies on 'a need to know' basis. The individual's consent to the sharing of information should always be sought. In certain circumstances, information about a person may be disclosed without their consent. **For further guidelines on this, please refer to the following guidance:**

- B&NES Multi-Agency Safeguarding Adults Policy and Procedures (2010)
- B&NES Multi-Agency Safeguarding Adults Information Sharing Protocol (2010)
- The Data Protection Act (1998)

7.4 Step Four – Safeguarding Adult procedures

B&NES Safeguarding Adult Procedures will be instigated where neglect is suspected in the development of a pressure ulcer. The strategy and planning meeting and the development of a protection plan must include all agencies involved with the case agreeing their respective roles and responsibilities with regard to actions/investigation. This must be clearly documented and recorded.

Where a pressure ulcer has developed, and the individual is assessed to lack mental capacity to consent to and engage with assessment, treatment and interventions, the Police must be consulted and a criminal investigation considered under Section 44 of the Mental Capacity Act 2005.

7.5 Step Five - Investigation

Where Safeguarding Adult procedures are instigated as a result of concerns relating to the development of a pressure ulcer, an investigation is likely to be requested by the Safeguarding Adult Chair to help determine whether neglect has occurred. NHS B&NES will be requested to review the standard and detail of assessment, documentation and evidence of the care regime. An independent clinical opinion will be sought if appropriate. Where cases are not subject to being reported as a Serious Incident (National Patient Safety Agency), an investigation report will be required as part of the Safeguarding Procedures **(see Appendix 3).** A second opinion should be sought if necessary

In March 2010, the National Patient Safety Agency (NPSA) published 'A National Framework for Reporting and Learning from Serious Incidents Requiring Investigation'. The framework details how all organisations providing NHS funded care should report, investigate and monitor serious incidents. The Organisation where the incident requiring investigation occurred has overall responsibility for the investigation and implementation of subsequent action plans. Investigations are conducted using a Root Cause Analysis (RCA), the level of which is determined by the grading of the incident. Timescales for investigation are clearly defined.

The definition of serious incidents requiring investigation is documented within the framework. For the purposes of safeguarding, such an incident may be determined further to an allegation of abuse under the following criteria:

- Death or injury to an adult at risk where abuse or neglect is suspected to be a factor

- Where an adult at risk has suffered harm as a result of staff failing to follow agreed procedures or acceptable practice

- When an adult at risk has suffered significant injuries suspected to be as a result of abuse

In the case where a patient has a pressure ulcer at Category 3 or 4 (EPUAP), the organisation where the incident occurred will undertake the RCA. It is acceptable for the RCA to be used as the mode of investigation and for the report to feed into Safeguarding Adult procedures.

Appendix 1

International NPUAP - EPUAP Pressure Ulcer Classification System (2009)

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Category 1 – Non blanchable redness of intact skin	Intact skin with non-blanchable skin erythema of a localised area usually over a bony prominence. Discolouration of the skin, warmth, oedema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching. ***Further description:*** The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category 1may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' persons
Category 2 – Partial thickness loss or blister	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 sero-sanginous filled blister. ***Further description:*** 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
Category 3 – Full thickness skin loss (fat visible)	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is *not* exposed. Some slough may be present. *May* include undermining and tunnelling. ***Further description:*** The depth of category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissues and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable
Category 4 – Full thickness tissue loss (muscle/bone visible)	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining or tunnelling.

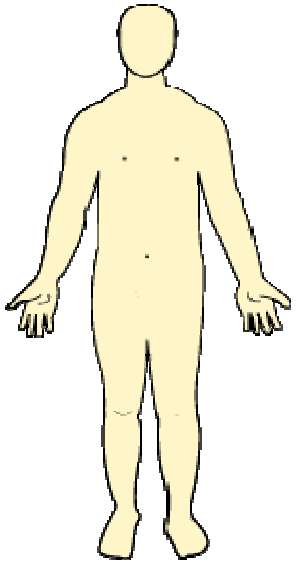
	Further description: The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nurse, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or oteitis likely to occur. Exposed bone/muscle is visible or directly palpable

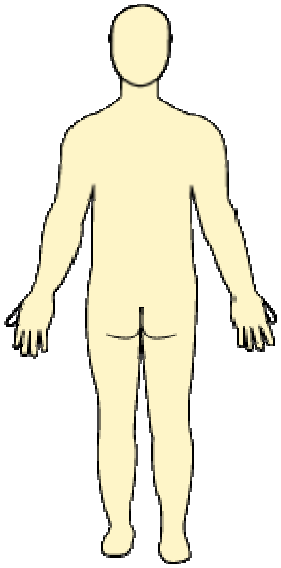
Appendix 2

Skin Condition Transfer Form

Surname	
Forename	
DOB	
Address	

On the figures below identify and number any marks or pressure ulcers present on the individuals body and describe in the table. Please also check for any warmth or hardness of tissue over bony prominences.





Pressure ulcer or marks Tissue warmth or hardness	Description/Dimensions EPUAP Category if a pressure ulcer	How and where mark or ulcer developed if known	Details of any current treatment
1.			
2.			
3.			
4.			
5.			
Please document here if the individual refuses assessment of any parts of the body:			
Please document any relevant information regarding mental capacity:			
Waterlow Score:			
Transfer form completed by: Name and contact number…… Designation…… Date……			

Appendix 3

Preparing a report for Adult Safeguarding

(Where an RCA has not been undertaken)

Information:

Full Name: …… Date of Birth ……/……/……

Hospital Number/NHS Number: **Place of Current Care:**

…….. ……..

Previous Place of Care: (if appropriate) ……..

Investigator Information and summary of Investigation:

Date of Report: **At the request of:**

Purpose of the Report:

Main findings:

Conclusions:

Recommendations (if appropriate):

DOCUMENTATION AVAILABLE AT TIME OF REPORTING:

Relevant past history:

This section should not include any opinion or subjective data

Please include the following and tick ✓ when attached/completed:

Factual information of pre injury status highlighting medical diagnosis	☐
Include the individuals detailed journey and events recording documented dates/times of assessment and actions taken (complete section below)	☐
Record risk factors and other details that would impact on the subsequent care and injury (complete section below)	☐

Factual information of pre injury status to include medical diagnosis:		
Date / Time	**Assessment**	**Action/s taken**
Risk Factors	**Impact (actual and potential) on Subsequent Care and Injury**	

Recent events and description of the incident:

This section should not include any opinion or subjective data

This should include detailed recent events that caused the situation to raise concern. *Raise issues that could contribute to injury or response to individuals' assessment. Assessment of mental capacity should be included*

Examination of the individual:

Describe the individuals' current status and include the date of examination. Include photographs if possible. If photos are taken, consent should be sought and documented using the relevant organisational consent policy. However, if there are clear issues of neglect which may lead to a criminal investigation, the individual refuses to allow photographs to be taken, further advice must be sought *Include details of wound assessment e.g. size (using a grid), colour and position etc.*

Management:

Report subsequent treatment and care including equipment, specialist care and investigations. This should include dates rationale for interventions, treatments and care.

Opinion based on above information:

This section should contain opinion but must be supported by the above information or evidence and references (in the form of policy/guidelines, standard practice) *If you have insufficient information to form an opinion, you should record as such.* *Ensure that the opinion is objective and can withstand scrutiny and questioning.*

Conclusion:

This must be objective and accurate

Recommendations:

Your opinion as to whether this case needs further information or investigation, perhaps second opinion and second examination

Author Details:

Name: …… Title ……

Place of Work: ……..

Qualifications that make you an expert able to comment on this case

……

Signed: …… Date: ……

2nd Reviewer Details (if appropriate):

Name: …… Title ……

Place of Work: ……..

Qualifications that make you an expert able to comment on this case

……

Conclusions:

- *Agree/Disagree*
- *Add comments*

Recommendations:

- *Agree/Disagree*
- *Add comments*

Signed: …… Date: ……

Appendices
E.g. photographic images and dates
Assessments

This information is confidential

Appendix 4

Flow chart to summarise the assessment process to determine if a pressure ulcer may have developed as a result of neglect

Alert raised for identified individual with pressure damage

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Consider the 3 key questions

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A) Is the adult Vulnerable?	**B) Is there evidence of neglect?**	**C) Are there concerns that all reasonable steps have not been taken to prevent the Pressure Ulcer?**
" All adults aged 18 and over who are or may be in need of community services by reason of mental or other disability, age or illness and who are, or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation."	Not all pressure ulcers in a vulnerable adult are the result of neglect Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support. In the context of pressure ulceration this failure has resulted in, or is highly likely to result in a preventable pressure ulcer.	If there are concerns an assessment of the care provided using the information available should be performed. Care should be assessed against available local and national best practice guidelines. A second opinion should be sought if considered necessary (consider tissue viability nurse)

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If the answer to all three questions is yes then the Safeguarding Adults Policy and Procedures must be instigated.