Kingston Safeguarding Adults Board

Richmond and Wandsworth Safeguarding Adults Board

South-West London Inter-agency Adult Safeguarding Protocols on:

Medication errors

Falls

Pressure Ulcers

Version 2	February 2022
Update due	February 2024

Contents

Medication Errors Protocol

1. Introduction

1.1. The Care Act 2014 defines Safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults.

1.2. The Safeguarding duties apply to adults who have needs for care or support (whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect; and 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. [DOH Care and Support Statutory Guidance, October 2014].

1.3. It is important that any medication errors are reported immediately and in line with the organisations policy and procedures if the health and wellbeing of service users is to be protected. The rapid reporting of errors means that prompt medical action can be taken where necessary.

1.4. All notifiable incidents should be reported to the CQC in line with the requirements of the Health and Social Care Act 2008 Regulations 2014. The law requires these notifications to be submitted within certain timescales – further guidance is available on what should be reported, how and in what timescales via the CQC guidance on Statutory Notifications.

1.5. This protocol provides guidance for health and social care staff to identify when a medication error should also trigger a safeguarding alert. The threshold for raising safeguarding alerts is purposefully low, all alerts will then be triaged in line with the safeguarding process and a proportionate response will be decided in line with the available evidence and the Making Safeguarding Personal approach

2. Purpose of the Protocol

2.1. This multi-agency protocol has been developed to assist in decision making as to whether to report a medication error as a safeguarding concern. It provides good practice guidance to support all agencies in making a referral decision. It is not a substitute for organisation's requirements to provide safe and effective care and to have an appropriate policy and procedures to guide staff.

2.2. Every organisation is responsible for ensuring that the protocol is used appropriately and monitor and review its use. This would include reviewing decisions to raise or not raise concerns within internal governance processes and managing medication errors within the organisations policy.

3. Defining Medication Errors

3.1. Two compatible definitions of medication errors are outlined in the following paragraphs (3.2 and 3.3).

3.2. The National Reporting and Learning Systems (NRLS) defines a 'patient safety incident' (PSI) as, 'any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS care.' Medication errors are any PSIs where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. These PSIs can be divided into two categories: errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose or a failure to monitor, such as international normalised ratio for anticoagulant therapy. In either case the act can be purposeful or accidental and it is only by looking and the specific circumstances of an incident that the intent can be ascertained. It is important to recognise that intent is only one factor in a safeguarding incident and that even where there is no intention to do harm the consequences of unintended errors can be significant.

3.3. A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. (National Coordinating Council for Medication Error Reporting and Prevention (www.nccmerp.org).

3.4. Medication incidents have a number of causes, such as lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor handwriting and instruction, and poor communication.

3.5. Errors may result in an incident or an adverse event. Where averted they can be classified as a 'near miss' and these would not ordinarily be subjects of safeguarding enquiries but will be dealt with through the providers internal protocols.

3.6. The National Institute for Care Excellence (NICE) published comprehensive guidance on "Managing medicines in care homes" on 14 March 2014 which may be of assistance to organisations in terms of developing and reviewing their medications policies see https://www.nice.org.uk/guidance/sc1

4. Statutory responsibilities

4.1. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

4.2. All medication errors including near misses must be recorded. This record must detail the impact of the error, any immediate action taken and record the date, time and names of staff and service users involved.

4.3. All medication errors should be reported in line with the care providers, management of incidents policy as soon as possible after the incident.

4.4. All medication errors should be reviewed and an action plan put in place to ensure lessons are learnt and the risk of the error being repeated is reduced. It is also important to review the error in the context of previously recorded errors as a series of similar incidents may meet the criteria for referral into safeguarding.

5. Managing medication errors in context of Adult Safeguarding

5.1. Not all medication errors should be regarded as needing a safeguarding enquiry

5.2. The pathway for safeguarding may be met when there is concern about possible abuse or neglect, involving the suspected experience or risk of actual harm. The following are examples of situations which could trigger a safeguarding referral (please note this is not an exhaustive list):

- The medication error is part of a **pattern**. The pattern could be same drug, same carer, same organisation or same vulnerable person. The **duration** and **frequency** must be considered via retrospective analysis.
- Medication is routinely administered **covertly** without appropriate consultation and supervision, including consideration of legal processes (including Mental Capacity and Mental Health Acts) and whether physical or psychological abuse applies.
- The provider response is not in accordance with their own protocols and procedures, or with national medicines safety guidance.
- There is a suspicion that medication has been deliberately withheld from or wrongly administered to the person
- A medication error requiring **medical intervention** e.g. beyond routine GP consultation, attendance at A&E

5.3. Staff should be aware of their own organisation's policies and procedures on medication management and other relevant local and national guidelines, protocols and policies e.g. NICE guidance, NMC, incident reporting policies. It must be acknowledged that there may be incidents where decision-making is not straightforward and professional judgement is required which must take account of the MCA.

5.4. Where there is doubt as to whether the incident meets the threshold for adult safeguarding referral a referral should always be made

6. Delegated enquires

6.1. The Care Act 2014 provides local authorities with the opportunity to "cause others to undertake enquiries", which is referred to as "delegating responsibility" for leading safeguarding enquires. In the case of medication errors, in many instances health care professionals within an organisation responsible for that individual's treatment will be best placed to lead these enquiries and so delegation should always be considered in the management of medication errors. A Safeguarding Adults (s42) Enquiry Planning Discussion, coordinated by the local authority, is the appropriate forum to decide on the scope of the enquiry to be addressed by relevant agencies.

6.2. Where the medication error meets the threshold in 5.2 above a safeguarding referral must be made to the local authority. The professional making the referral should have a discussion with the designated local authority decision maker as to whether there should be a multi-agency safeguarding enquiry or whether the enquiry should be delegated to the provider organisation. A summary of the discussion will be recorded by the local authority and shared with the agencies involved in the discussion.

6.3. The principles of Making Safeguarding Personal should be adhered to and therefore there should be a discussion with the patient (and/or their representative or advocate) in terms of what they want to happen in terms of undertaking an enquiry. It should be clearly

agreed who will have this discussion. In determining with whom it is most appropriate to hold the discussion, the principles of the Mental Capacity Act should be considered.

6.4. If the enquiry is delegated at the Planning Discussion stage, the partner should gather information using their own documentation (including serious incident/root cause analysis) and make a recommendation as to whether the medication error constituted abuse or neglect. This should be completed by an appropriately skilled and trained person within the organisation.

6.5. The outcome of the medication error enquiry should be sent to the local authority. This will include information on:

- Whether the risk was removed, reduced, or remains.
- Whether the persons desired outcomes were met
- The impact of the enquiry on the persons sense of safety and well being
- The actions to be undertaken to embed learning

6.6. The local authority officer will record the information from the delegated enquiry for reporting to the Safeguarding Adults Partnership board.

6.7. If a full enquiry is to be undertaken the local authority will lead on the enquiry following local procedures.

7. Review

7.1. This protocol will be reviewed every two years.

References

"Managing medicines in care homes", Social care guideline [SC1] March 2014

Falls Protocol

1. Introduction

1.1. The Care Act 2014 defines Safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults. In the case of falls it is imperative to balance risk and the ability of people to live the lives they want to live. In the words of Justice Munby "What good is it making someone safe if it merely makes them miserable?"

1.2. Falls and injuries in hospital, community and residential settings are common due to physical frailty of adults at risk, the presence of a long-term condition such as Parkinson's disease, dementia or arthritis or being unfamiliar with the environment. There are general measures which can reduce the risk of falls such as undertaking a risk assessment and developing a personalised care plan to manage the risks. It is vital that all CQC regulated providers have well documented policies and protocols which highlight best practice in their organisation. Safeguarding is not a substitute for good local procedures.

1.3. The National Institute for Health and Care Excellence (NICE) have published a quality standard in March 2015, which covers assessment after a fall and prevention of further falls (secondary prevention) in older people living in the community and during a hospital stay. The guidance can be found at http://nice.org.uk/guidance/qs86

1.4. This protocol will enable health and social care staff to identify when a fall could have been caused as a result of neglect and whether an enquiry under the safeguarding procedures should take place.

2. Purpose of the Protocol

2.1. This multi-agency protocol has been developed to assist in decision making as to whether to report a fall as a safeguarding concern. It provides good practice guidance to support all agencies in making a referral decision. It is not a substitute for organisations requirements to provide safe and effective care and to have an appropriate policy and procedures to guide staff.

2.2. Every organisation is responsible for ensuring that the protocol is used appropriately and monitor and review its use. This would include reviewing decisions to raise or not raise concerns within internal governance processes and managing risk of falls within the organisations policy.

3. Falls and safeguarding

3.1. The 2015 NICE Quality Standards defines a fall as an unexpected loss of balance resulting in coming to rest on the floor, the ground or on an object below the knee. A fall is distinct from a collapse which is as a result of an acute medical condition such as arrhythmia, transient ischaemic attack (TIA) or vertigo

3.2. Falls and fall related injuries are a common and serious problem for older people, particularly those with underlying conditions and pathologies. Falls are a major cause of

disability and the leading cause of mortality for those aged 75 and above. Most falls do not result in injury but annually approximately 5% of older people living in the community who fall experience fractures or need hospitalisation. The Royal College of Physicians 2011 report (Falling Standards Broken Promises) highlight that falls and fractures in people over 65, account for 4 million hospital bed days each year in England alone.

3.3. People with care and support needs have an increased risk of falling compared to the general population due to their physical frailty, underlying medical conditions, muscle weakness, poor balance, medication or unfamiliarity with a new environment.

3.4. The human cost of falling includes distress, pain injury, loss of confidence, loss of independence and mortality. Falling also has an impact on the family members and carers of people who fall. The consequences are exacerbated if people do not receive quick and appropriate assistance at the time of the fall.

3.5. Not all falls can be prevented but best practice requires that a multifactorial falls risk assessment should be in place as part of the overall care plan. This assessment and the care plan should be discussed and agreed with the person and their representative in line with the principles of Making Safeguarding Personal. If the person lacks the capacity to understand the risk assessment and proposed care plan then an advocate or representative should be consulted and agree the risk assessment and proposed plan using the principles of the Mental Capacity Act.

3.6. In terms of a falls risk assessment, care planning and risk management, these should be undertaken at a number of key points in a person's journey of care for example:

- pre-admission to the hospital/care/nursing home/ intermediate care/home care
- admission to the hospital/care/nursing home/ intermediate care/home care
- at any point when the resident/service user's needs change
- after a fall

3.7. All organisations offering care and support in a hospital, community, own home or care home setting should have a clear policy in place as to how falls are documented. It is recommended that this should be recorded as a specific incident which captures the following:

- Whether the risk assessment was up to date and the plan followed
- Documents any harm and action taken to help the person at the time of the fall
- The actions taken to prevent further falls

4. Managing Falls in context of Adult Safeguarding

4.1. Not all falls should be regarded as needing a safeguarding enquiry

4.2. The threshold for safeguarding is met when there is concern about possible abuse or neglect. The following situations would trigger a safeguarding referral:

- Where a person sustains an injury due to a fall, and there is a concern that a risk assessment and care plan were not in place or were not followed. The key factor is that the person has experienced *avoidable* harm.

- Where a person has fallen and appropriate medical attention has *not* been sought in a reasonable time frame and in accordance with the organisations policy, this must be reported as a safeguarding concern. *Note: specific falls guidance states that where*
  the person has sustained a head injury, a medical assessment should always be arranged as a matter of urgency.
- Where there is concern that the circumstances and nature of the fall or explanation given are not consistent with the injury sustained.
- Where the organisations own post falls protocol is not in place or has not been followed.

4.3. A safeguarding concern does not need to be raised when:

- A person is found on the floor, there is no evidence of injury and all care has been delivered in accordance with the falls policy.
- A fall is witnessed, and appropriate risk assessment is in place and has been followed.
- The falls is attributable to an acute medical condition or episode which has occurred recently i.e. in the past hours or days.
- The person made a capacitated decision about their own risks which is clearly documented.
- There was no risk assessment in place as this was not a foreseeable risk i.e. this is the first fall

4.4. It must be acknowledged that there may be incidents where decision-making is not straightforward and professional judgement is required which must take account of the MCA and people's rights to take risks and to make unwise decisions. In all cases ensure that the reasons for the decision are recorded.

4.5. Where there is doubt as to whether the incident meets the threshold for adult safeguarding referral a referral should always be made.

5. Delegated enquires

5.1. The Care Act 2014 provides local authorities with the opportunity to "cause others to undertake enquiries", which is referred to as "delegating responsibility" for leading safeguarding enquires. In the case of falls, in many instances health care professionals within the organisation responsible for that individual's treatment will be best placed to lead these enquiries and so delegation should always be considered in the management of falls.

5.2. Where the fall meets the threshold in Paragraph 4.2, a safeguarding referral must be made to the local authority. The professional making the referral should have a discussion with the designated local authority decision maker as to whether there should be a multiagency safeguarding enquiry or is if the enquiry should be delegated to the provider organisation. A summary of the discussion will be recorded by the local authority and shared with the agencies involved in the discussion.

5.3. The principles of Making Safeguarding Personal should be adhered to and therefore there should be a discussion with the patient (and/or their representative or advocate) in terms of what they want to happen in terms of undertaking an enquiry. It should be clearly

agreed who will have this discussion. In determining with whom it is most appropriate to hold the discussion, the principles of the Mental Capacity Act should be considered.

1.1. If the enquiry is delegated the partner should gather information and make a recommendation as to whether the fall constituted abuse or neglect. This should be completed by an appropriately skilled and trained person within the organisation.

5.4. The outcome of the falls enquiry should be sent to the local authority. This will include information on:

- Whether the risk was removed, reduced, or remains.
- Whether the persons desired outcomes were met.
- The impact of the enquiry on the persons sense of safety and well-being.
- The actions to be undertaken to embed learning.

5.5. The local authority officer will record the information from the delegated enquiry for reporting to the Safeguarding Adults Partnership board.

5.6. If a full enquiry is to be undertaken the local authority will lead on the enquiry following local procedures.

6. Review

6.1. This protocol will be reviewed every two years.

Protocol on Safeguarding Adults Enquiries for different types of Pressure Ulcers

1. Introduction

1.1. Safeguarding is defined as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults.

1.2. 1.2. Pressure ulcers develop when the skin integrity breaks down. This may be caused by poor practice, acts of omission or neglect but in some instances, they are unavoidable.

1.3. This protocol will enable health and social care staff to identify if it is likely the pressure ulcer was caused as a result of neglect and whether an enquiry under the safeguarding procedures should take place. It will provide a focus on thresholds for referral through the safeguarding adult process. It is based on the multiagency integrated pressure ulcer pathway developed by NHS England In May 2014.

2. Purpose of the Protocol

2.1. This multi-agency protocol has been developed to assist in decision making as to whether to report a pressure ulcer as a safeguarding concern. It provides a decision guide which aims to support decisions about appropriate responses to pressure ulcer care and whether concerns need to be referred into the local authority.

2.2. It provides guidance for staff in all sectors who are concerned that a pressure ulcer may have arisen as a result of neglect/abuse or act of omission and therefore have to decide whether to make a referral to social services. A flow diagram outlining the key elements of the protocol can be found in Appendix 1.

2.3. Each organisation is responsible for ensuring that the protocol is used appropriately and monitor and review its use. This would include reviewing decisions to raise or not raise concerns within internal governance processes.

3. Pressure ulcers and safeguarding

3.1. Neglect is a form of abuse which involves the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support, where this has resulted in, or is highly likely to result in, significant preventable skin damage.

3.2. Skin damage has a number of causes, some relating to the individual person, such as poor medical condition and others relating to external factors such as poor care, ineffective Multi-Disciplinary Team working, lack of appropriate resources, including equipment and staffing. **It is recognised that not all skin damage can be prevented and therefore the risk factors in each case should be reviewed on an individual basis before a safeguarding referral is considered.** All cases of actual or suspected neglect should be referred through the safeguarding procedures.

3.3. There are **Six** recognised grades of pressure ulcers in the Wound Classification system drawn up by the European Pressure Ulcer Advisory Panel (EPUAP 2019). See below

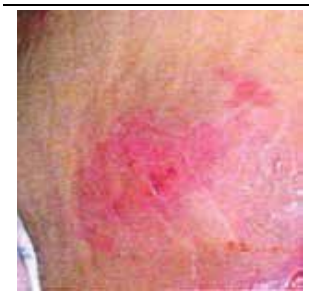
INTERNATIONAL NPUAP/EPUAP PRESSURE ULCER CLASSIFICATION SYSTEM (2019)

Category I: Nonblanchable 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).

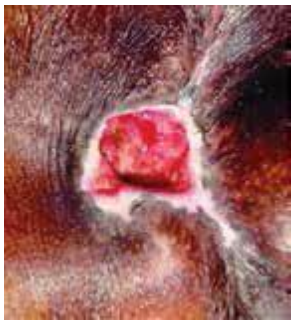


Category II: Partial Thickness Skin Loss

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 serumfilled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

**Bruising indicates suspected deep tissue injury.*



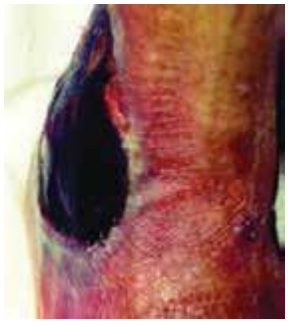
Category III: Full Thickness Skin Loss

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 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 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 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 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, gray, 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.

4. Managing Pressure Ulcers in context of Adult Safeguarding

4.1. As outlined in the NHS England 2014 Guidance, all cases of single Grade 2 pressure ulcers require early intervention to prevent further damage. If there are concerns regarding poor practice, a clinical incident must be raised and investigated through the NHS provider organisations own procedures.

4.2. Any ungradable, or grade 2 and above pressure ulcers MUST be reviewed under the pressure ulcer criteria and local clinical governance procedures followed.

4.3. A safeguarding referral should be made if there is:

- Significant skin damage (i.e. Category 3 or 4, ungradable pressure ulceration or multiple Category 2s) and
- There are reasonable grounds to suspect that there were inadequate measures taken to prevent development of pressure ulcer (including informal carers preventing access to care or services), or
- Inadequate evidence to demonstrate the above

4.4. In deciding about the need for a safeguarding referral, a history of the problem should first be obtained, contact former care providers for information if the person's care has recently been transferred, and seek clarification about the cause of the damage.

4.5. Safeguarding concerns should be raised when pressure ulcers are reported by anyone including carers, relatives and patients, as any tissue damage no matter who reports it should be investigated.

5. Procedure to determine if a pressure ulcer is due to neglect of an adult at risk

5.1. As soon as a pressure ulcer Category 3 or 4 or ungradeable is identified there should be an assessment of the wound by the team responsible for that individual's treatment. Completion of the pressure ulcer decision guide (see Appendix 2) must be completed by a qualified member of staff who is a practicing registered nurse, with experience in wound management. This does not have to be a Tissue Viability Nurse.

5.2. The safeguarding decision guide involves 6 key questions which together indicate a safeguarding decision guide score (See Appendix 2). This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the potential of neglectful care/management resulting in the pressure ulceration. The threshold for referral is 15 or above. However, this should not replace professional judgement.

5.3. Photographic evidence should be used to support the report wherever possible, provided that the service user consents. Body maps should be used to record skin damage and can be used as evidence if necessary at a later date. If two workers observed the skin damage they must both sign a body map. Documentation of the pressure ulcer must include site, size (centimetres) and category/grade.

5.4. The Safeguarding Decision Guide should be completed immediately or within 3 working days of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension must be documented.

5.5. Where the patient has been transferred into the care of the organisation it may not be possible to complete the decision guide. Contact should be made with the transferring organisation to ascertain if a safeguarding concern has been raised or the decision guide has been completed; if neither then a safeguarding concern should be raised with the local authority.

6. Delegated enquires

6.1. The Care Act 2014 provides local authorities with the opportunity to "cause others to undertake enquiries", which is referred to as "delegating responsibility" for leading safeguarding enquiries. In the case of pressure ulcers, in many instances health care professionals within the organisation responsible for that individual's treatment will be best placed to lead these enquiries and so delegation should always be considered in the management of pressure ulcers. The process for determining whether or not undertaking an enquiry into a pressure ulcer should be delegated to the provider organisation is summarised in Appendix 1.

6.2. When the pressure ulcer protocol has been completed and there is no indication of neglect, the completed screening tool should be stored in the patient's notes and a record kept of the screening outcome.

6.3. Where there is a cause for concern, a safeguarding referral must be made to the local authority. The professional making the referral should have a discussion with the designated local authority decision maker as to whether there should be a multi-agency safeguarding enquiry or if the enquiry should be delegated to the provider organisation. A summary of the discussion will be recorded by the local authority and shared with the agencies involved in the discussion.

6.4. If the enquiry is delegated to the reporting health partner, the work of the enquiry will involve either a concise or a comprehensive Root Cause Analysis. This should be completed by an appropriately skilled and trained person such as District nurse team lead, ward manager or nursing home manager in line with the providers pressure ulcer or risk management policies.

6.5. The principles of Making Safeguarding Personal should be adhered to and therefore there should be a discussion with the patient (and/or their representative or advocate) in terms of what they want to happen in terms of undertaking an enquiry. It should be clearly agreed who will have this discussion. In determining who it is most appropriate to hold the discussion with the principles of the Mental Capacity Act should be considered.

6.6. The outcome of the Root cause Analysis findings may be sent securely to the local authority Enquiry Officer on request. This final Safeguarding outcome will include information on:

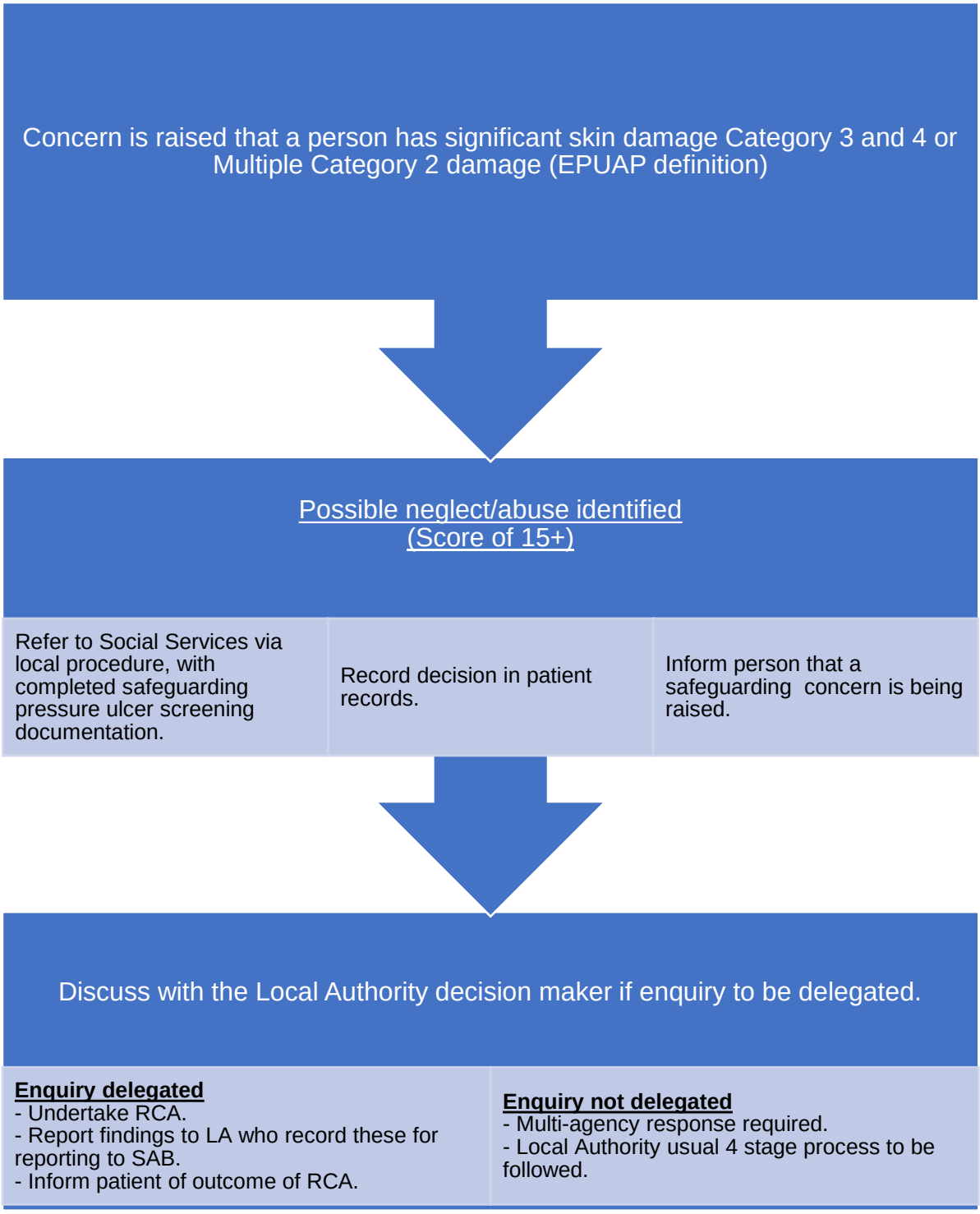
- Whether the risk was removed, reduced or remains.
- Whether the person's outcomes were met
- The impact of the enquiry on the person's sense of safety and well being

- The actions to be undertaken to embed learning
- The local authority officer will record the information from the delegated enquiry for reporting to the Safeguarding Adults Partnership board.
- If a full enquiry is to be undertaken the local authority will lead on the enquiry following local procedures.

7. Review

7.1. This protocol will be reviewed every two years.

Appendix 1: Pressure Ulcer Delegation of enquiry process chart



Appendix 2: Pressure Ulcer decision Guide

Has the person's skin deteriorated to Category 3/4, unstageable or multiple sites of Category 2 ulceration from healthy unbroken skin?
This guide should be completed where the skin damage developed under the care of your organisation / service

Q	Risk Category	Level of Concern	Score	Evidence
1	Has there been a recent change, (days or hours), in their clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anaemia, end of life skin changes, other illness which could impact in skin integrity.	**No concern** Change in condition likely to contribute to skin damage	0	
		Concern No change in condition that could contribute to skin damage	5	
2	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? Is the care plan in line with each organisation's policy and guidance?	**No concern** No previous skin integrity issues OR new episode of care.	0	
		No concern Current risk assessment and care plan carried out by a health care professional and documented appropriate to the person's needs.	0	State date of assessment Risk tool used Score / Risk level
		Some concern Risk assessment and care plan carried out and documented but not reviewed as the person's needs have changed.	5	Describe this.
		Concern No or incomplete risk assessment and/or care plan not carried out	15	Describe what should have been in place.
3	Is there a concern that a carer has neglected the person's needs? For example, by not providing appropriate skin care, ignoring advice or preventing access to healthcare?	**No concern** No / Not applicable	0	
		Concern Yes	15	
4	Is the skin damage consistent with the person's risk status for pressure ulcer development?	**No concern** Skin damage consistent with or less severe than the person's risk status.	0	
		Concern Skin damage MORE severe and/or disproportionate to the person's risk status.	10	
5	**Answer A if no concerns with the person's mental capacity to consent to their care plan'. Answer B if the person is assessed as lacking capacity to consent to some / all of their care plan.**			
A	Was the person compliant with the care plan (having had information about the risks of non-compliance)?	Person not compliant with care plan	0	
		Person partially compliant	3	
		Patient compliant with care OR not given information for informed choice.	5	
B	Was appropriate care given in the patient's best interests (as per MCA) and recorded clearly.	Records evidence care given in best interests.	0	
		No recoded evidence of care given in the person's best interests.	10	
TOTAL SCORE				

If the score is 15 or over refer as a safeguarding concern. Send this form as your safeguarding referral.

When the protocol has been completed, even when there is no indication that a safeguarding concern needs to be raised the tool should be stored in the patient's notes.