NHS England

Safeguarding Adults Prompt Cards

- Your responsibilities
- Categories of abuse
- Your role as an alerter
- Information sharing

Subjects aligned to safeguarding principles

- Pressure Ulcers
- Self neglect
- Domestic abuse
- Forced Marriage/"honour" violence/killing
- Female Genital Mutilation
- Prevent
- Channel
- Resources

NHS ENGLAND INFORMATION READER BOX

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Foreword

The way the NHS provides care to vulnerable individuals at a time when they need our help most should be our absolute priority and act as a true litmus test of quality of care more broadly in the NHS.

Making sure that we stop abuse in whatever shape or form for our patients has to be paramount. Embracing the 6C's and the Dignity in Care work will go a long way to prevent the likelihood of abuse happening.

However, there will be time when you will come across abuse and it is important that you know what you have to do. These prompt cards will act as a reminder of what is required of all of us to protect adults at risk of abuse. They should always be used as a reference and you will need to adhere to your local policies and procedures.

There are some areas in your daily practice that are about stopping abuse, but which may not be specifically regarded as safeguarding. Therefore these prompt cards have been expanded to include domestic abuse; female genital mutilation; forced marriage/ family violence; self neglect, pressure ulcers and Prevent.

Raising awareness about the MCA which applies to all of us is a key priority for the NHS and therefore warrants a stand alone card.

Remember to contact your local safeguarding adult lead locally if you need further advice or support.

We hope you find this resource useful.

Caroline Alexander:
Chief Nurse NHS England (London)

Equality Assurance

"Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it."

Your responsibilities

Safeguarding adults

All staff within services have a responsibility for the safety and wellbeing of patients and colleagues.

Living a life that is free from harm and abuse is a human right of every person and an essential requirement for health and wellbeing.

Safeguarding adults is a fundamental part of patient safety and is an ambition in the NHS Outcome Framework. Safeguarding adults is also integral to complying with legislation, regulations and delivering cost-effective care.

These prompt cards should be used by you as a guide for when you have a safeguarding concern, and should always be used alongside your organisations, regional and national safeguarding policies.

Involving the person at risk in their own safeguarding is key to obtaining the best outcomes for the person, so that where possible they can decide what they want to do to feel safer, and consider how they can best protect themselves from abuse in the future.

Definition of an adult at risk of abuse by a third party

Aged 18 years or over; and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation. Usually this means that they are or may be in need of community care services by reason of mental or other disability, age or illness.

NB: Throughout this publication we have used the term 'patient' to refer to patients and clients.

Your responsibilities when you have safeguarding concerns:

- **Assess** are emergency services required?
- **Communicate**
- **Record**
- **Share Information**

Duty of care

You have a duty of care to your patients, as have your colleagues, and your employer, and all should act in the public interest. Everyone has a duty of care; it is not something that you can opt out of.

The Health Professions Council standards state:

> 'A person who is capable of giving their consent has the right to refuse treatment or referral. You must respect this right. You must also make sure they are fully aware of the risk of refusing treatment, and it's likely consequences including a significant or immediate risk to life.'

Duty of care can be said to have been reasonably met where an objective group of professionals consider:

- All reasonable steps have been taken
- You have provided clear information to the patient
- Reliable assessment methods have been used
- Information has been collated and thoroughly evaluated
- Decisions are recorded, communicated and thoroughly evaluated
- Policies and procedures have been followed
- Practitioners and managers have sought to ascertain the facts and are proactive.

You should always treat every individual with dignity and respect to ensure that they feel safe in services and empowered to make choices and decisions. Be guided by the Compassion in Care principles outlined in the '6 Cs':

- **Care –** is of the best quality and always safe.
- **Compassion –** is not just about the care we give, but the way we give it; seeing the person in each and every patient and modelling compassionate care for others to follow.
- **Courage –** to do the right thing; speak up and challenge when things are wrong; be open to being challenged ourselves; overcome barriers to make things happen; lead by example; be unafraid to make suggestions; don't give up!
- **Communication –** Is not just talking, but observing and active listening it is also about sharing ideas and concerns with a wide range of people.
- **Competence –** Has to be maintained to flourish, we need *confidence* in what we are doing and in those around us but fundamentally we need our patients and the public to have confidence in us.
- **Commitment –** To be accountable, to be transparent in your communication; ensuring contemporaneous records that are clear and support the delivery of the right care to the right person at the right time.

Involve others

Ensure that significant others, such as a family member, friend or advocate, are involved to support the individual. This is particularly important when the patient lacks capacity. Family members cannot give consent for health or social care treatment on behalf of a patient over 16 years, but their views are important and should be considered by you the decision maker. It is important to find out **who** has the legal responsibility to make decisions on behalf of the patient whose capacity to make a decision is impeded.

- Ask if a deputy has been appointed by the Court of protection?
- Ask if the patient has appointed a Lasting Power of Attorney – is there a copy, has it been registered with the Court of Protection? – Is that for health and welfare or managing property and financial affairs or both?

However, it is important to recognise that though an individual with capacity has the right to refuse care for themselves, the duty of care extends to considering where others may be at risk and action is needed to protect them.

Refer to the Mental Capacity Act Prompt cards, or your organisational policies to guide you through the process.

Follow the six safeguarding principles through each step to safeguard the patient:

Empowerment – Presumption of person-led decisions and consent; Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent, such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision they will still be included in decisions to the extent that they are able. Decisions made must respect the person's age, culture, beliefs and lifestyle and their background.

Protection – Support and representation for those in greatest need.

There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

Prevention – Avoiding harm or abuse is a primary goal. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within health and care services by all staff groups.

Proportionality and choosing the least intrusive response appropriate to the risk presented; responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive to the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

Partnerships – You will need to communicate and make links with staff from other organisations within the community.

Accountability – and transparency in delivering safeguarding. Services are accountable to patients, public and to their governing bodies. Working in partnerships also entails being open and transparent with partner agencies about how safeguarding responsibilities are being met.

(Adult safeguarding: updated statement of government policy DH 2013)

Categories of Abuse

All categories of abuse must be carried out by another person (a third party) and abuse may be intentional or unintentional.

- **Physical** – assault, rough handling, unreasonable physical restraint.
- **Psychological/emotional** – bullying, intimidation, verbal attack or other behaviour that affects the wellbeing of an individual.
- **Sexual and sexual exploitation** – any non-consenting sexual act or behaviour.
- **Financial** – theft, fraud, misappropriating funds i.e. when using a person's money or property for self-gain or gratification.
- **Neglect** – a person's wellbeing is impaired and care needs not met.
- **Discrimination** – psychological abuse that is racist, sexist or linked to a person's sexuality, disability or age.
- **Institutional** – observed lack of dignity and respect in the care setting, rigid routine, processes/tasks organised to meet staff needs, disrespectful language and attitudes.

Significant harm

The impact of harm upon a person will be individual and depend upon each person's circumstances and the severity, degree and impact or effect of this upon that person.

The following would indicate that the effect of harm for the person is likely to be significant:

- The person's life could be or is under threat, for example due to neglect or physical abuse.
- There is or could be a serious, chronic and/or long lasting impact on the person's health / physical / emotional / psychological well-being.
- The person has little or no choice or control over vital aspects of their life, environment or financial affairs.

(Law Commission 2010)

If in doubt contact your nominated lead for adult safeguarding in your organisation:

Your role as an alerter

Your role as 'alerter' in the safeguarding process

The 'alerter' raises a safeguarding concern within their own agency following that agencies own policy and procedures. This concern may result from something that you have seen, been told, observed or heard.

Contact the police where a crime has been committed: a person is in immediate danger or where there are any other safeguarding risks.

Assessment

Your assessment should be holistic and thorough considering the patient's emotional, social, psychological and physical presentation as well as the identified clinical need.

- **Ensure the safety and wellbeing of the patient – Is immediate protection required?**
- **Has a crime been committed and should the police be informed? Do you need to preserve any evidence?**
- Inform the person that you may be required to share the information, explaining what information will be shared and why
- **Be clear about** the patient's views and wishes in relation to the abuse and what they would like to happen next. (Do not presume to know what the patient may want)
- Maintain any evidence and follow internal procedures for reporting incidents / risks
- Remain calm and try not to show any shock or disbelief
- Listen carefully and demonstrate empathy

You need to be alert to:

- Patient's vulnerability
- Barriers in seeking or receiving treatment such as lack of reasonable adjustment for disabled people; cultural differences
- Skin integrity, hydration or personal presentation, e.g. is the person unkempt?
- Evidence of frequent attendances to health services or repeated failure to attend (DNA)
- Environmental factors, e.g. signs of neglect, the reactions, responses and behaviour of other people with the patient
- Inconsistencies in the history or explanation

- Patient's capacity for the decision required? Are they able to give informed consent or is action needed in their best interests?
- Risk to others such as children or other adults?
- Actions that are being considered being proportionate to the risk identified?
- Reasons that may require you to act even without the patient's consent; where others are at risk or you need to address a service failure that may affect others?

Golden rule: A holistic assessment should be carried out, at the initial contact or on admission and discharge, in a community or an acute setting in order to fulfil your duty of care to adults at risk.

Communication

- Listen carefully, remain calm and try not to show shock or disbelief and acknowledge what is being said
- Consider use of communication aids/ language line if required to involve the patient
- Take account of individual differences such as those covered under equality legislation
- Do not ask probing or leading questions that may affect credibility of evidence. Be open and honest and do not promise to keep a secret
- Seek consent to share information if the patient has capacity and if this does not place you or them at increased risk
- You may share information without consent if it is in the public interest in order to prevent a crime or protect others from harm (follow your own organisation's policy and procedures)

Reporting

- Report concern following your safeguarding adults and serious incident procedures.
- **Make a clear and concise referral to the Local Authority, without delay, so that the person reading the form understands the key issues.**
- Concern about a colleague should be raised through your organisation's Managing Allegations against staff or Whistleblowing policy.

Remember that you are accountable for what you do or choose not to do.

Recording

- You are accountable for your actions or omissions.
- Make a legible, factual, timely and accurate record of what you did and why it was appropriate to do so.
- Show your decision making process to demonstrate transparent, defensible decision making, for example any capacity assessment you made; best interest decisions that were taken; and where restraint including chemical restraint was required that it was proportionate to the situation.

Remember: A failure to record could be seen as an indicator that intervention did not occur.

Think of potential additional referrals you may need to make such as to safeguarding children team where this is necessary.

Information Sharing

Whistle blowing

Always act whenever abuse is suspected including when your legitimate concern is not acted upon. It is always best to raise concerns first with your line manager or safeguarding lead; however there is a national helpline that can also give you independent advice. To speak to a helpline advisor you should telephone: **08000 724 725**. NHS Employers has a useful website on whistleblowing aimed at front line staff. Whistle-blowers are given protection under the Public Interest Disclosure Act 1998.

Where there are safeguarding adult concerns staff have a duty to share information. **It is important to remember that in most adult serious case reviews, lack of information sharing is identified as a significant factor *in failing to stop abuse.***

Staff should consider "**What information should I share and with whom to manage this risk?"**

Information about an adult at risk should be shared with consent wherever possible. **Remember that the Data Protection Act is not a barrier to sharing information,** but provides a framework to ensure that personal information is shared appropriately.

A patient's right to confidentiality is not absolute and may be overridden where there is evidence that sharing information:

- is necessary to support a criminal investigation or prosecution.
- is in the public interest (such as in the interests of public safety or the safety of other vulnerable people or children).
- Is in the best interest of a person who lacks the capacity to decide on whether information should be shared to manage their risk of abuse.

Please follow your own organisation's Information Governance Policy.

Remember:

Be open and honest with the person at risk from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

Seek advice on whether and what information you can share if you are in any doubt, without disclosing the identity of the person where possible.

Seek consent and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.

Consider safety and well-being and base your information sharing decisions on considerations of the safety and well-being of the person or persons at risk of abuse and others who may be affected by their actions.

Information shared needs to be necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary to safeguard the person at risk, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

Keep a record of your decision and the reasons for it – whether it is to share information or not.

If you decide to share, then record what you have shared, with whom, and how that would assist in safeguarding the person at risk. Equally record your rationale for not sharing. Then record this in the person's personal record.

Always refer to your Information Governance Policy

Key points

Information disclosed should be:

- **Clear regarding the nature of the problem and the purpose of sharing it.**
- **Based on fact, not assumption.**
- **Restricted to those with a legitimate need to know.**
- **Relevant to a specific incident.**
- **Strictly limited to the needs of the situation at that time but should include relevant patient history.**
- **Recorded in writing, with reasons stated.**

Sharing information when a patient lacks mental capacity

Can the patient give consent to disclosure of information?

You have a responsibility to explore approaches to help the patient understand.

In some instances the individual will not have the capacity to consent to the disclosure of personal information relating to a specific incident.

In those instances information can be shared if it is deemed to be in the patient's best interest.

There are circumstances in your daily practice where you can identify risk and stop abuse, but which may not be specifically regarded as safeguarding. Accordingly these prompt cards have been expanded to include some such areas:

- Domestic Abuse
- Forced Marriage/Family Violence
- Female Genital Mutilation (FGM)
- Self Neglect
- Pressure ulcers
- Prevent.

Domestic Abuse

Is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

This decision making tree should always be used in conjunction with your local policy and guidelines.

THE ROUTINE ENQUIRY | **ASK 'THE QUESTION'**

Research indicates women want to be asked if they are experiencing domestic abuse

'About one in four women inthe UK will experience domestic abuse at some point in their lives. We also know that domestic abuse sometimes starts for the first time in pregnancy. Are you experiencing domestic abuse?' 'We ask all women this question routinely'.

'Has your partners ever hit you?' 'Are you afraid at home?' 'How does your partner react when he's angry / under the influence of alcohol?' 'What happens if you disagree with your partner?'

'You seem quiet' 'How are things?' 'How are things at home?' 'How are things with your partner?' 'Are you feeling well supported?' 'How is your partner coping?' 'Are they looking after you?' 'How does your partner respond when you say how you feel?'

'That's a nasty bruise / scratch.' 'How did that happen?' 'Is everything alright at home?' 'Can you talk about it?' 'I am wondering if someone has hurt you'.

'You seem a bit down / quiet, Is everything OK?' 'How are you feeling?' 'Is something happening at home?'

No Disclosure

The women should be offered a 'domestic abuse information' card or leaflet.

A response such as 'I don't need that' warrants a reply such as 'Good, but because violence to women is so common, perhaps you could hold onto it so that if someone in the family, a neighbour or friend talks to you about this you could use it then.'

If this is likely to cause safety issues where the perpetrator may find the card, then say 'Good, but you know where you can find information should you or someone you know be affected by violence.'

Disclosure

If a woman reponds positively to an enquiry about domestic abuse it is important to be non-judgemental and offer support.

For example: 'I am sorry to hear that you are living with domestic abuse. You have shown great courage in disclosing this information'. Do you know abou the services available to help you?' 'What might be helpful to you?' 'Who do you know who can support or help you?'

Emphasise 24hr Domestic Violence free phone help line number.
'Would you like me to phone them for you or arrange a meeting for you?'

Safety Plan

The client must not inform the perpetrator of any intended plan. Emphasise this is for client's safety.
Discuss how the written information you give to a client, and the personal terms discussed in the safety plan, can be kept safe from the perpetrator. This may entail the worker holding information on behalf of the woman.

The safety plan should include:

- Identifying a safe place to go to (friends/relative/police station)
- Money for the phone, bus or taxi
- Extra set of keys for the house or car
- Birth / marriage certificates, benenfits / rent books, passports
- Address book / list of emergency numbers
- Children's favourite toys / photos / mementoes
- Making plans for pets
- Clothes
- Baby food / nappies, etc

Men can also be victims of domestic abuse and there can be domestic abuse in same sex relationships.
However, the majority of victims are women.

Domestic Abuse is a health issue and healthcare staff should be aware of the extent and seriousness of this problem.
Women living with domestic abuse are:

- 9 times more likely to abuse drugs
- 15 times more likely to abuse alcohol
- 3 times more likely to be diagnosed as depressed or psychotic
- 5 times more likely to attempt suicide

Domestic Abuse?

Face the Facts and Ask 'The Question'
The Routine Enquiry

A patient's vulnerability may make it more difficult for them to report abuse or leave a situation – be mindful of this.

45%–75% of children living with domestic abuse are likely to be abused themselves by the same perpetrator

Ask the question sensitively when patient is alone-respond with emphatically
Document when you ask the question and the response

The following may inhibit disclosure of abuse and needs to be considered when seeing a patient
- Having learning difficulties
- Having a physical disability
- Family member maybe abuser
- Communication difficulties
- Challenging behaviour

No Disclosure of Domestic Abuse

Offer local available information. Women's Aid 24 hr Helpline to all women

Still concerned? Why?

Periodically keep asking 'The Questions'

Be alert to the signs of abuse and patients vulnerability

Periodically keep asking 'The Questions'

Give Information Safely

Women's Aid National 24hr Helpline 0800 2000 247

Violence helpline for men 0808 2000 247.

999 in Emergency
Local Domestic Abuse Support
Explore Options

Disclosure of domestic abuse. Explain the limits to confidentiality of the disclosure and what actions you may have to take

Serious risk to the patient/or other – refer case to MARAC

If in immediate risk call 999

No Safeguarding Children Issues

Are there any children or vulnerable adults? Consider concerns about a child's safety including unborn baby

Information Sharing
Liase with GP/MW/ HV/SN/Police/Social Care/keyworker (follow LSCB/LSAB Guidelines)

Discuss with Child Protection Lead/manager/ Adult Protection Lead.

Remain concerned?

Inform Parent/Carer need to refer to Social Care (if appropriate and safe Informed consent is needed for adults. Please See MCA prompt cards for consent issues.)

Refer to Social Care

Best Practice Always talk to the patient alone when asking about abuse
- Never pressure a patient to leave partner
- Discuss and ensure a safety plan is in place
- Reinforce options
- Explain the role of expert agencies
- Give helpline number
- Advise dialling 999 in an emergency
- Always use a professional interpreter never a family member or a client's friend, if English not first language
- Always ensure complex domestic abuse cases are brought to supervision for discussion
- Document all contacts, when asking 'The question', disclosures, actions, observations etc

Two women every week are murdered by their current or ex-partners
All children living with domestic abuse suffer emotional harm

Forced marriage and family violence

A forced marriage is a marriage in which one or both spouses do not (or, in the case of some adults with learning disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure. Motives for forced marriage may include controlling unwanted behaviour and sexuality.

Forced Marriage Unit (FMU)

The contact for Forced Marriage Unit Commonwealth Office and Home Office unit 020 7008 0151. For out of hours emergencies, please telephone 020 7008 1500 and ask to speak to the Global Response Centre.

'Honour'-based violence

The terms "honour crime" or "honour-based violence" Or "izzat" embrace a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder, where the person Is being punished by their family or their community for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. Those who do leave often live in fear of their own families who will go to considerable lengths to find them and ensure their return.

Sometimes, having traced them, the family may murder them (so called "honour killing") or subject them to further violence or abuse.

The "One Chance" Rule

You may only have one chance to speak to the patient and thus may only have one chance to save a life! If in immediate danger, with consent, call the police.

Create an environment that encourages open discussion: Display relevant information such as details of the Freephone National Domestic Violence Helpline; NSPCC; Asian Child Protection Helpline; Child Line; Care line and appropriate black and minority ethnic women's Groups.

Female Genital Mutilation (FGM)

FGM or cutting is a cruel violation of a girls/woman's rights and entitlement to bodily integrity and includes mutilation of a female's genitals, including the partial or total removal of the external genitalia. The practice has intolerable long-term physical and emotional consequences and for this reason the UN has recognised FGM as torture and calls for its elimination. It is estimated that 66,000 women living in England and Wales have undergone FGM and with increased migration from countries where FGM is widely practiced (see next page) more girls and women are at risk of undergoing FGM. This is despite FGM being illegal since 1985 and in 2003 this included FGM performed on UK citizens and permanent residents outside the UK.

What can you do?

- Identify girls and women at risk of FGM as early as possible- such as baby girls born to mothers who have undergone FGM; be aware of the age at which females are subjected to FGM in countries where it is practiced.
- Advise FGM is unlawful and harmful.
- Encourage them to speak to police as a crime may have been committed.

They can speak in confidence to **Crime stoppers on 0800 555111**

And/or **NSPCC FGM dedicated helpline on 0800 0283550**

Safeguarding girls (0-18) at risk of harm through FGM poses specific challenges because the families involved may give no other cause for concern with regard to their parenting responsibilities or relationships with their children. However, there remains a **duty for all professionals to act to safeguard girls at risk of FGM under** Working Together 2013. **Anyone who has information that a child is potentially or actually at risk of significant harm must make a Child protection referral to the Local Authority.**

Identify girls/women who are likely to be subjected to or have have undergone FGM.

- All females regardless of age presenting with FGM within the NHS must be considered as potential victims of crime with complex needs.
- Any interpreter used should be an authorised accredited interpreter and should not be a family member, nor known to the individual, and not be an individual with influence in the individual's community.

- Women should have the law on FGM as well as their choices about prosecution explained to them –even though a woman may not want to prosecute a member of their own family.
- Referral to police should be considered with the woman's consent if she has capacity to give it. Children should be referred within local child protection policy guidelines.

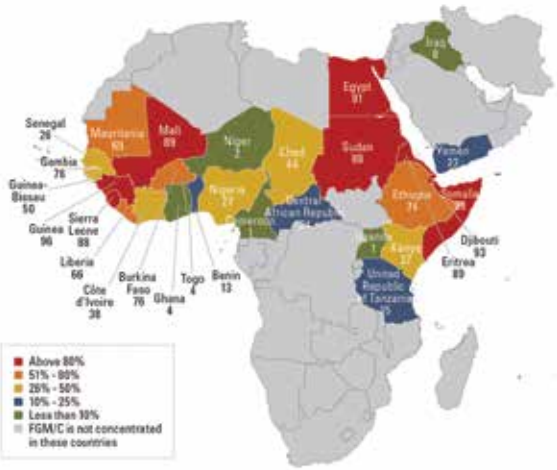
Refer for care those who have suffered the complications of FGM to

NHS Specialist Services for Female Genital Mutilation – There are several clinics available in London and in many large UK cities. Most clinics are run by specially trained doctors, nurses, or midwives. To refer please follow your local pathway.

Countries where FGM is widely practiced

Map 4.1 FGM/C is concentrated in a swath of countries from the Atlantic Coast to the Horn of Africa

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country



United Nations Children's Fund, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, UNICEF, New York, 2013, p. 26.

Self Neglect

Safeguarding Adult procedures under 'No Secrets' guidance only applies to adults at risk who are allegedly being abused or neglected by another person (an adult or child).

Therefore, if an adult at risk, or other vulnerable person is neglecting their own physical or mental health, personal care, hygiene, nutrition or other basic needs and is, or believed to be, at risk of significant harm to their health or well-being as a result, this does not currently come under the scope of safeguarding adult procedures.

The autonomy of an adult with capacity needs to be respected but where an adult at risk or other vulnerable person is self-neglecting and is at high risk of significant harm to their health or well-being staff need to continue all efforts to building and maintaining supportive relationships through which services can in time be negotiated. The importance of interagency communication, collaboration and the sharing of risk is important.

In cases of serious or severe self-neglect, staff should consider if there is any significant underlying cause for it and or whether it is a capacitated choice and an unwise decision by the person who is self-neglecting. Consider factors such as mental illness, depression organic disorders, toxic states, ill health, learning difficulties or disabilities and make appropriate reasonable adjustments.

Staff have a duty of care to *consider and* take action if there are potential referrals or interventions to protect the person who is self-neglecting from further harm. Refer to the Mental Capacity Act (MCA).

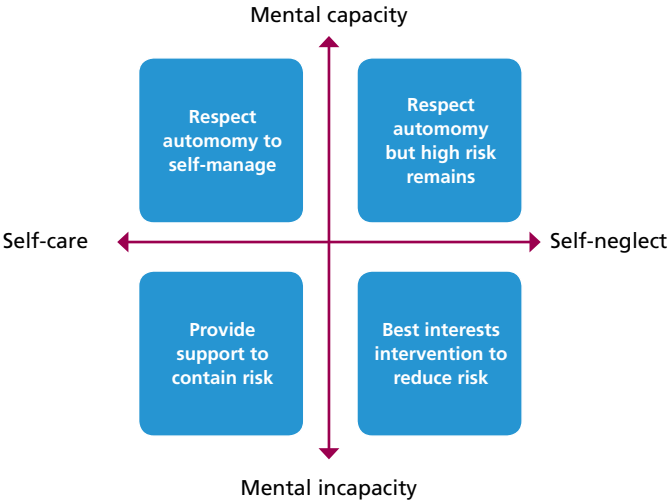
Where a patient lacks capacity to make a decision regarding self care follow the best interest flowchart in the MCA prompt cards or your organisational procedures.

For advice about helping a patient who is neglecting themselves contact your lead for adult safeguarding in your organisation.

The diagram below tells you what your likely response should be depending on your patients capacity and level of self care skills.

The interface between

Mental Capacity and Self Neglect



Pressure Ulcers

Preventing pressure ulcers should be a key priority for all agencies and may or may not be an indicator of abuse. They do however have a significantly adverse affect upon a person's quality of life and should be prevented.

- All care, support and explanation for patients who are at risk of developing pressure ulcers or who have pressure ulcers has to be done within the principals of the Mental Capacity Act.
- The engagement of, carers, paid and unpaid and legal representatives (holding Lasting Power of Attorney) for Health and welfare and relatives should be evident.
- Patients should receive an initial and on-going risk assessment within 6 hours of the first episode of care.
- Those assessed as at risk should be cared for as guidance suggests dependent upon the degree of risk.
- This should include a care plan that records the frequency of pressure area care required/skin care regime and the type of pressure relieving equipment required.
- The optimum environment should be created to maintain skin integrity or where compromised the ideal wound healing interventions. This will include satisfactory maintenance/referral/management of nutrition and hydration, hygiene, continence care and maintaining mobility.
- Good communication is essential, which would include accurately recorded assessments; care/treatment plan; transfer/discharge forms and includes open/transparent and appropriate information sharing between agencies.

Safeguarding considerations

- Any pressure ulcer may be an indicator of neglect/abuse; therefore all should be appropriately assessed and screened to identify any possible safeguarding concerns.
- Not all grade 3/4 pressure ulcers are indicative of abuse/neglect.
- Patients must be involved and empowered to engage with all stages of the safeguarding process and, their preferred outcome must be recorded.
- Once a safeguarding concern is identified, a safeguarding alert must be raised within the guidelines of the local policy and procedures timescales to safeguard adults from abuse.
- Keep up to date with best practice/evidence through learning the lessons from the investigation process.

Pressure Ulcer Grading

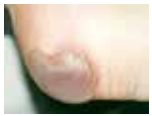
To support your practice

Pressure Ulcer Grading (Adapted from EPUAP/NPUAP 2009)

Superficial

EPUAP- Category/Grade I

- Non-blanchable erythema of intact skin: persistent redness in light pigmented skin.
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple.
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).



EPUAP System Category/Grade 2

- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising*
- Check for moisture lesion.

*Bruising appearance and blood filled blister would indicate deep tissue injury.

Deep

EPUAP- Category/Grade 3

- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep grade 3 pressure ulcers.
- Bone/tendon is not visible or directly palpable.

Plus: Unclassified Phow Grade 3

- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either grade 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as 'the body natural (biological) cover' and should not be removed.
- Should be documented as grade 3 until proven otherwise.

EPUAP- Category/Grade 4

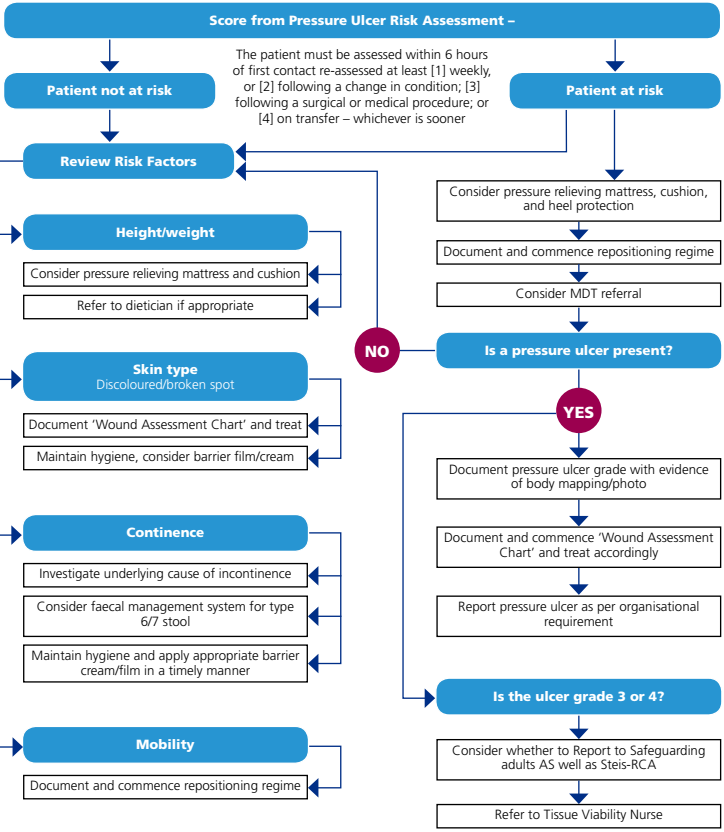
- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow.
- Grade 4 ulcers can extend into the muscle and/or supporting structures (eg fascia, tendon or joint capsule).

Moisture Lesions

- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.

Pressure Area care

Flowchart



Prevent

Building Partnerships, Staying Safe

The radicalisation of vulnerable individuals is the process by which people come to support any form of extremism and, in some cases, join terrorist groups. It has the potential to cause significant harm to the vulnerable individual and others and is therefore aligned to the safeguarding principles within the NHS. The Prevent programme exists to stop people being groomed into terrorist activity by providing vulnerable individuals with support and interventions ***before*** any crime is committed, it therefore operates in a pre-criminal space.

What is the role of the health service in Prevent?

Frontline staff have a key role in Prevent because of the high numbers of daily interaction with patients, service users and others. There will be occasions where healthcare workers meet and treat individuals who may be open to exploitation by radicalisers. It is important that if there are signs that someone has been or is being drawn into terrorism, healthcare workers can interpret those signs correctly. There is no single way of identifying who is likely to be vulnerable. Factors may include: peer pressure, influence from other people, via the internet, bullying, crime and anti-social behaviour, family tensions, race/hate crime, lack of self esteem or identity and personal or political grievances. It is important to be aware of unusual changes in a person's behaviour which are a cause of concern.

Support and intervention are available for the individual being radicalised, and these are described on the next page.

Prevent requires front line staff to raise concerns with confidence and in accordance with their organisational policies and procedures, usually to their line manager and Prevent or Safeguarding Leads.

To support staff and individuals there are close partnership working between health, Local Authorities and the Police and health organisations are now required to have a dedicated Prevent Lead. Information can be provided through the Safeguarding Lead.

Further information can be obtained via

- Workshops to Raise Awareness of Prevent (WRAP). These are being rolled out across England to develop understanding of the Prevent agenda, as well as the impact that radicalisers can have on vulnerable individuals.
- Building Partnerships, Staying Safe: the healthcare contribution for healthcare workers can be found on *https://www.gov.uk/government/publications/the-health-sector-contribution-to-hm-government-s-prevent-strategy-guidance-for-healthcare-workers*

Speak to the Prevent or Safeguarding Lead for further information and guidance.

Channel

Supporting vulnerable adults who show signs of radicalisation

There is support for individuals who may be susceptible to a terrorist ideology and show signs of being groomed into terrorist activity. This is called Channel.

How does Channel work?

Channel works by identifying individuals who may be at risk. Person centred support packages are offered to the individual depending on their need. The type of support offered depends on an initial assessment of the nature and the extent of any risk and a multi agency assessment considering their circumstances. This then decides the most appropriate action to protect an individual. Each support package is monitored closely and reviewed regularly by a multi-agency panel. The multi agency approach of Channel supports frontline staff in sharing risks around individuals with key partners.

Any concern about an individual should be raised with a senior manager and Prevent or Safeguarding Lead who will then be able to make a referral. To find out more about Channel please refer to the NHS England Protocol for Prevent Referrals which will be held with your Prevent or Safeguarding Lead or search for the Channel guidance under *www.gov.uk*

What happens with the referral?

- Each referral is screened for suitability. If the referral is not appropriate for Channel an exit strategy will be planned.
- Appropriate referrals will go through a preliminary assessment coordinated by the Channel coordinator.
- Partners will be asked if the vulnerable individual is known to their service and an assessment will be completed to present to the Channel Group.
- The multi-agency panel will convene and be chaired by the local authority, support needs will be identified and action plan will be drafted.
- Each case will be reviewed a minimum of every six weeks.
- There will be a six-monthly and 12-monthly review for each case.
- In the normal course of events appropriate consent should be obtained from the individual involved. There may be exceptional circumstance where this may not happen as in other safeguarding referrals. Refer to the information sharing section and consult with your Safeguarding Lead.

Channel is part of the Prevent strategy and provides a multi-agency partnership that works with existing safeguarding partnerships and crime reduction panels in order to assess referrals of vulnerable individuals that are at risk of being drawn into terrorism. Channel is administered and coordinated by police, but chaired by the local authority.

Further discussions and support can be given by your Prevent or Safeguarding lead.

Resources

For the resources listed below, visit:

Adult Safeguarding Resources and Reports from Social Care Institute for Excellence:

http://www.scie.org.uk/adults/safeguarding/index.asp

Adult Safeguarding Community of Practice:

http://www.communities.idea.gov.uk/comm/landing-home.do?id=2962596

Building Partnerships, Staying Safe: the healthcare contribution for healthcare workers can be found on https://www.gov.uk/government/publications/the-health-sector-contribution-to-hm-government-s-prevent-strategy-guidance-for-healthcare-workers

Channel: Protecting vulnerable people from being drawn into terrorism. A guide for local partnerships' (October 2012) http://www.acpo.police.uk/documents/TAM/2012/201210TAMChannelGuidance.pdf

Clinical Governance and Adult Safeguarding: An integrated process (DH 2010). http://www.nmc-uk.org/Documents/Safeguarding/England/1/Clinical%20governance%20and%20adult%20safeguarding.pdf

Female Genital Mutilation leaflet: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261326/FGM_leaflet.pdf

Free online Safeguarding Training http://www.e-lfh.org.uk/home/

Free online e-learning courses http://www.e-lfh.org.uk/home/

Mental Capacity Act 2005 in primary care E-learning toolkit www.mcahealth.net

Multi-agency Practice Guidelines-Handling cases of Forced Marriage Statutory Guidelines for handling Forced Marriage**:** https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35530/forced-marriage-guidelines09.pdf .

NHS Employers Website: http://www.nhsemployers.org/Pages/home.aspx

Nursing and Midwifery council http://www.nmc-uk.org/safeguarding/

Pressure Ulcer Guidelines**:** http://www.epuap.org/ http://www.npuap.org/ http://guidance.nice.org.uk/CG29

Royal College of Nursing http://www.rcn.org.uk/development/practice/safeguarding

Social Care Institute for Excellence: http://www.scie.org.uk/publications/reports/report41/identifyingpeopleatrisk.asp

Specialist centers for Female Genital Mutilation**:** http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-health-services-for-women.aspx

www.nationaldomesticviolencehelpline.org.uk

www.stopthepressure.com to find out more about what you can do to prevent pressure ulcers via tools resources and case studies.

Acknowledgements

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