Reporting Skin Damage in a Vulnerable Adult as a Safeguarding Alert

“A vulnerable adult is a person “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”

The term “community care services” includes all social and health care services provided in any setting or context. The term “harm” should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment that are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health. It should also be taken to include the impairment of physical, intellectual, emotional, social or behavioural development.

Cornwall and Isles of Scilly Multiagency Safeguarding Adults Policy April 2010

Author: Chris Nash
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1) Definition of Skin Damage

This countywide guidance is for staff working all areas of healthcare provision who are concerned that skin damage may have arisen as a result of poor practice, neglect, acts of omission or deliberate harm. For the purpose of this document the definition of skin damage includes: Pressure damage, skin tears, grazes, bruises etc.

The term patient has been used throughout – however this also refers to residents in care homes and those living in their own homes.

All services will be provided in a manner that respects the rights, dignity, privacy and beliefs of all individuals concerned and does not discriminate on the basis of race, culture, religion, language, gender, disability age, or sexual orientation.

2) Aim of the guidance

This guidance should be used to decide whether to raise a safeguarding alert and if applicable report as a serious incident requiring investigation in respect of skin damage. A flow diagram outlining the key elements of the guidance can be found on page 5.

Neglect is 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 preventable skin damage.

Skin damage has a number of causes, some relating to the individual patients, such as chronic illness or nutrition and others relating to external factors such as poor nursing care or lack of resources e.g. equipment or staffing. Not all cases will give rise to a safeguarding alert (see page 3 and 4)

When a member of staff identifies skin damage an initial assessment must be carried out by a registered nurse. This assessment must be documented using Appendix 2 contained within this guidance. Advice on completing the assessment can be obtained from the Tissue Viability Team on 01566 765652 (Community) and 01872 252673 (Royal Cornwall Hospital Trust).

Where the patient is assessed to have a pressure ulcer graded at level 3 or 4 and the patient is in receipt of NHS funded care, consideration should be given to reporting this also as a Serious Incident Requiring Investigation (SI). Guidance on reporting and investigating SI’s can be found within the providers local Policy and Procedure for Reporting and Learning from Serious Incidents Requiring Investigation (SIRI).
Where a grade 3/4 pressure ulcer is found on a NHS funded patient residing in a care home and where there has been no input from other health services this should be reported as a commissioning SI.

Where a patient is assessed by a service and is found to have a grade 3 or 4 pressure ulcer but the patient is not in receipt of NHS funded care this should be reported as a SIRI by NHSCIOS if any neglect by NHS health care personnel has been established on initial investigation.

All cases of actual and suspected neglect should be referred through the safeguarding adult’s procedures. Although not all poor practice is neglect, some may be. Poor practice will also need to be reported through the safeguarding procedures to ensure that all areas of concern are appropriately addressed.

Consideration should also be given to reporting cases of actual and suspected neglect as a SIRI.

Cases of actual/suspected neglect or poor practice should always be discussed with your line manager/team leaders prior to making an Alert. You can also take advice from your Named Professionals for Safeguarding Adults. Named Professionals should be informed of all cases where a safeguarding alert has been made.

Safeguarding alerts (including completion of the SA22 form) must be completed and sent to the Safeguarding Adults Access Team by email, FAX or post. You can contact the Access Team on 0300 1234 131

NB. If alleged abuse has occurred in a care home the Care Quality Commission must be informed (regulation 37).
3) **Assessment Process**

In all cases consider these three questions:

- Are there concerns that reasonable steps have not been taken to prevent skin breakdown or are there acts of omission or deliberate harm?
- Is the adult vulnerable?
- Is there evidence of neglect, acts of omission or deliberate harm?

3.1 **Are there concerns that reasonable steps have not been taken to prevent skin breakdown or are there acts of omission or deliberate harm?**

If there are concerns about whether reasonable steps to reduce the risk of skin damage were taken, the care given should be assessed against available local and national guidance. A second opinion should be sought if necessary.

Assistance with evaluating the information collected and specialist advice is available from the Tissue Viability Team.

3.2 **Is the adult vulnerable?**

Please see front sheet of policy for definition.

3.3 **Is there evidence of neglect, omission or deliberate harm?**

Not all skin damage in a vulnerable adult is the result of neglect.

Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support, and that this has resulted in, or is likely to result in (when considering other vulnerable adults in the same situation), preventable skin damage.

However the key questions to ask which apply to all settings are:

- Would the illness, behaviour or disability of the vulnerable adult have reasonably required the continuing assessment of skin condition (where no monitoring has taken place prior to serious skin damage occurring)?

- If continuing assessment was then refused by the vulnerable adult/family was it reasonable for advice to be sought? If yes, the patient’s mental capacity must be considered. If the patient is deemed to lack capacity regarding this process then a decision needs to be taken in their best interests. The family has no right to refuse continuing assessment.
• If continuing assessment was agreed, was the frequency of the assessment appropriate for the condition as presented at the time?

• Would continuing assessment have shown changes in the 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 the appropriate expert assistance sought? If so did that result in a care plan/equipment provision appropriate to address the pressure care needs of the vulnerable adult? Did the care plan address the management of risks that should have been reasonably identified? (e.g. the high risk of non compliance by the patient or informal carer)

3.4 If the answer to all 3 questions above is yes:

A safeguarding Adults alert must be made as per your Trust protocol. (including completion of the SA22 form).
When should the development of skin damage lead to a Safeguarding Adults Alert and/or reporting of a Serious Incident Requiring Investigation?

Concern is raised that a person has skin damage (refer to definition of skin damage on page two). Complete incident reporting in line with trust requirements. Please note that if skin damage is considered to be pressure related at grade 3/4 this should be reported also as a serious incident in accordance with trust guidelines.

Is the patient a vulnerable Adult (refer to definition on front page)

Registered nurse to consider the 3 questions, using the form in Appendix two. If the answer is YES to all 3

Yes

Make Safeguarding Adults alert by telephoning The Access Team on 0300 1234 131. Follow up this referral by completing a SA22 and copying to relevant Named Professionals as per your own trusts protocols.

No

Safeguarding adults alert not made and the rationale for this decision is documented in the Nursing Notes Refer to Tissue Viability Team if required

If this answer to Q3 is yes consider reporting also as SIRI

Decision made to raise a safeguarding adult alert based on response to 3 key questions, in consultation with team leader/line manager. Advice can also be accessed from Tissue Viability Team/Safeguarding Adults Named Nurse. (Refer to Multiagency Safeguarding Adults Policy if necessary)
Appendix Two

Assessment to be used when determining if development of skin damage should lead to a Safeguarding Adults Alert

This assessment must be completed by a registered nurse and a copy sent with the SA22.

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1) Have reasonable steps been taken to prevent skin damage?

Yes [ ] No [ ]

a. list what steps have been taken to prevent skin damage:

b. list any reasonable steps you would have expected that have not been taken:
2) Is the level of damage to skin disproportionate to the patient’s risk status for skin damage development? Eg: low risk but extensive injury:

   Yes [ ]  No [ ]

   If yes, please explain (use body maps to identify areas of damage):

3) Is there evidence of poor practice or neglect?

   Yes [ ]  No [ ]

   a. List evidence of poor practice:

   b. List evidence of neglect:

Rationale for referral/non referral: