Final Version.

Reporting Skin Damage in an Adult as an Adult Safeguarding Concern

Adult Safeguarding duties apply to an adult who:

- Has need for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of abuse and neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect.

The Care Act 2014

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## Index

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim of the guidance</td>
<td>Page 2</td>
</tr>
<tr>
<td>Assessment process</td>
<td>Page 4/5</td>
</tr>
<tr>
<td>When should the development of skin damage lead to an Adult Safeguarding Alert and/or reporting of a Serious Incident?</td>
<td>Appendix One</td>
</tr>
<tr>
<td>Assessment to be used when determining if development of skin damage should lead to a Adult Safeguarding Alert</td>
<td>Appendix Two</td>
</tr>
</tbody>
</table>
1) **Definition of Skin Damage**

This countywide guidance is for staff working in 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 an adult 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 and acts of omission consist of:
- ignoring medical,
- emotional or physical care needs
- failure to provide to provide access to appropriate health, care and support or educational services
- the withholding of the necessities of life, such as medication, adequate nutrition and heating

*Care Act 2014*

Preventable skin damage may occur as a result of the withholding or un-intentional failure to provide appropriate and adequate care and support.

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 01726 627595 (Community) and 01872 252673 (Royal Cornwall Hospital Trust).
Where the patient is assessed to have pressure ulcer damage that meets the criteria as a Serious Incident (as defined in the National Serious Incident Framework NHS England 2015) consideration should be given to reporting it in line with the guidance, which can be found in the National Framework, the FAQs that accompany it and local policies and procedures.

Where pressure ulcer damage that meets SI criteria 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.

All cases of actual and suspected neglect should be referred through the adult safeguarding procedures. Although not all poor practice is neglect, some may be and needs to be established through appropriate channels. Evidence of 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 SI.

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

A safeguarding alert must be made via phone to the Multi-agency Referral Unit (MARU) on 0300 123 1116.

NB. The Care Quality Commission must be informed of alleged abuse occurring in regulated services such as hospitals and care homes.
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?
- Does the adult have needs for care or support?
- 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. **Do the safeguarding duties apply to the adult?**

Please see front sheet for details.

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

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

The key questions to ask which apply to all settings are:

- Would the illness, behaviour or disability of the 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 adult and/or their family/carers 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/carers have 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 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:**

An adult safeguarding alert must be made as per your Trust protocol.
Appendix One

When should the development of skin damage lead to an Adult Safeguarding Alert and/or reporting of a Serious Incident (Serious Incident Framework 2015/16 frequently asked questions Question 5)?

<table>
<thead>
<tr>
<th>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 and meets SI criteria this should be reported also as a serious incident in accordance with your organisational guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do the safeguarding duties apply to this adult?</td>
</tr>
<tr>
<td>Registered nurse to consider the 3 questions, using the form in Appendix two. If the answer is YES to all 3</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Make Adult Safeguarding alert by telephoning The Multi-agency Referral Unit (MARU) on 0300 123 1116 and ensure named professional for your organisation is notified as per your own trusts protocols.</td>
</tr>
<tr>
<td><strong>No</strong></td>
</tr>
<tr>
<td>Adult Safeguarding alert not made and the rationale for this decision is documented in the Nursing Notes. Refer to Tissue Viability Team if required</td>
</tr>
<tr>
<td>If this answer to Q3 is yes consider reporting also as safeguarding SI</td>
</tr>
<tr>
<td>Decision made to raise an Adult Safeguarding 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</td>
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</table>
**Appendix Two**

**Assessment to be used when determining if development of skin damage should lead to an Adult Safeguarding Alert**

This assessment must be completed by a registered nurse and a copy stored in the patient record.

<table>
<thead>
<tr>
<th>Name of patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal address of patient</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Hospital/NHS number</td>
</tr>
<tr>
<td>Place of current care</td>
</tr>
<tr>
<td>Previous place of care (if appropriate)</td>
</tr>
<tr>
<td>GP or Consultant</td>
</tr>
</tbody>
</table>

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: