TEESWIDE

SKIN DAMAGE/ PRESSURE ULCER

PROTOCOL

August 2011

Contents

Appendices

Deciding whether to refer to the Teeswide Interagency Partnership Safeguarding Adults Procedures

Aim of Protocol

This protocol gives guidance to staff in all sectors in Tees when they are concerned that a pressure ulcer (or other skin damage) may have arisen because of poor practice or neglect and therefore have to decide whether to make a safeguarding referral within Teeswide Inter-Agency Safeguarding Adults Procedural Framework. A flow chart outlining the key elements of the protocol can be found in **Appendix 1**.

Skin damage can have a number of causes; some that relate to individual patients. However it could be because of poor practice or neglect. This protocol helps staff when considering whether a pressure sore is caused through neglect and whether a safeguarding referral is required.

Neglect and acts of omission includes :

The deliberate withholding of, or unintentional failure to provide a necessary level of care and support for an adult to meet his or her identified/assessed needs. Active neglect is a refusal to meet care-giving obligations. Passive neglect is a general failure to fulfil those obligations.

Where either type of neglect results in the impairment of, or an avoidable deterioration in physical or mental health this is considered ill-treatment.

The Teeswide Vulnerable Adult Safeguarding procedures provides examples of indictors that may signal signs of neglect or acts of omission are taking place; this could include 'poor physical condition, e.g. skin ulcers or excoriation, pressure sores or a pale or sallow complexion.'

All cases of suspected abuse, including through neglect or acts of omission should be referred through Teeswide Inter-Agency Safeguarding Procedures.

How to use the protocol

When a member of staff identifies a possible safeguarding concern about skin damage an initial assessment must be carried out (**Appendix 2**) to ascertain whether a safeguarding referral should be made.

When a pressure sore has developed it would be expected that timely medical advice would be sought from a registered nurse to provide assessment and treatment, and to seek specialist advice where necessary. The registered nurse should at this time consider whether abuse can be ruled out and if not arrange for the prompt completion of the assessment tool.

The assessment should be carried out by at least two members of staff, one of whom must be a practising registered nurse. The assessment must be documented on the report form in **Appendix 2**. Advice in completing the form can be obtained from a tissue viability nurse.

The Referral Process

If it is agreed following the completion of the assessment form that neglect/abuse is suspected then a referral should be made by telephoning social care directly.

You may have other reporting mechanisms within your organisation, (e.g. completion of an incident reporting form etc). However if the person is an adult at risk (see page 4 for further information) and abuse is suspected a safeguarding referral is also required under Teeswide Inter-Agency Safeguarding Procedures.

Information required when making a referral

Social care will require the following information when you make a referral.

- The referrers Details.
- The name of the identified adult at risk and their contact information.
- Relevant details of their gender, race, faith, culture and any special communication or access needs.
- Details and circumstances of abuse.
- Risk factor.
- Impact on the adult concerned.
- Setting / location of incidents or alleged abuse.
- Occasions when it took place.
- The name and date of birth of the alleged perpetrator(s) if know.
- Identity of any witnesses.
- Any immediate action taken to safeguard the adult, including contact with the police or other emergency services and a crime number if appropriate.
- Details of care that has been carried out to treat the pressure damage and to prevent further damage, and details of who has undertaken that care.
- Determination of and reference to an individual's mental capacity.

Where the referrer has identified that a pressure sore is a sign of possible abuse they should state that they have completed a skin damage assessment form (refer to **Appendix 2**) and this should be faxed or sent to social care direct as soon as possible after the referral is made

For more information on the referral process please refer to the Teeswide Inter-Agency Procedural Framework.

Initial Assessment

The assessment must consider five key questions:

1. Has there been rapid onset and /or deterioration of skin integrity?

2. Has there been a recent change in medical condition e.g. skin or wound infection, other infection, pyrexia, anaemia, end of life care that could have contributed to a sudden deterioration of skin condition?

3. Have reasonable steps been taken to prevent skin damage?

4. Is the level of damage to the skin disproportionate to the patient's risk status for skin damage? e.g. low risk of skin damage with extensive injury.

5. Is there evidence of poor practice or neglect?

Photographic evidence to support the report should be provided wherever possible. Consent for this should be sought. The photographs must show the size of the wound within the picture (e.g. by using a wound measure) and be taken using a camera that transcribes the date and time on the photograph.

Is the patient an adult at risk?

Teeswide Inter-Agency Policy defines a vulnerable adult as:

'someone aged eighteen or over, who is or may be eligible for community care services and whose independence and well-being would be at risk if they did not receive appropriate health and social care support.'

The person may have a physical impairment, a sensory loss, or a learning disability – perhaps present from birth or due to advancing age, chronic illness or injury. They might self-harm, be dependent upon or misuse substances such as alcohol or drugs, or experience physical or mental ill-health.

It is important to remember however, that a person does not have to be receiving community care services to be classed as an **adult at risk**. Adults not in receipt of community care services can also be considered at risk. They may, for example, be receiving care from family or have refused services in the past. They may be self funding or continuing health care funded. This protocol is relevant to all adults considered to be at risk.

If you have any doubt about whether someone is classed as an 'adult at risk' seek advice from the Safeguarding officers in your area of work.

Deciding whether a referral should be made

The assessment questions in **Appendix 2** are designed to assist in making a professional judgment and decision on whether a safeguarding referral should be made. In deciding whether to make a referral you should consider the following points.

- If in question 3 you have answered that reasonable steps had not been taken to prevent skin damage you need to consider if neglect has occurred. If you cannot rule out the possibility of abuse or neglect a safeguarding referral should be made.
- If your answer to question 4 is yes, the level of damage is disproportionate to the patient's risk status, and you cannot rule out neglect or abuse as the reason for this a referral should be made
- You do not need to prove that the pressure damage is as a result of abuse or neglect before making a referral. If you have identified evidence of possible poor practice or neglect in question 5 a referral should be made.
- It is important to remember that one type of abuse does not always happen in isolation. Therefore when considering pressure damage you should also

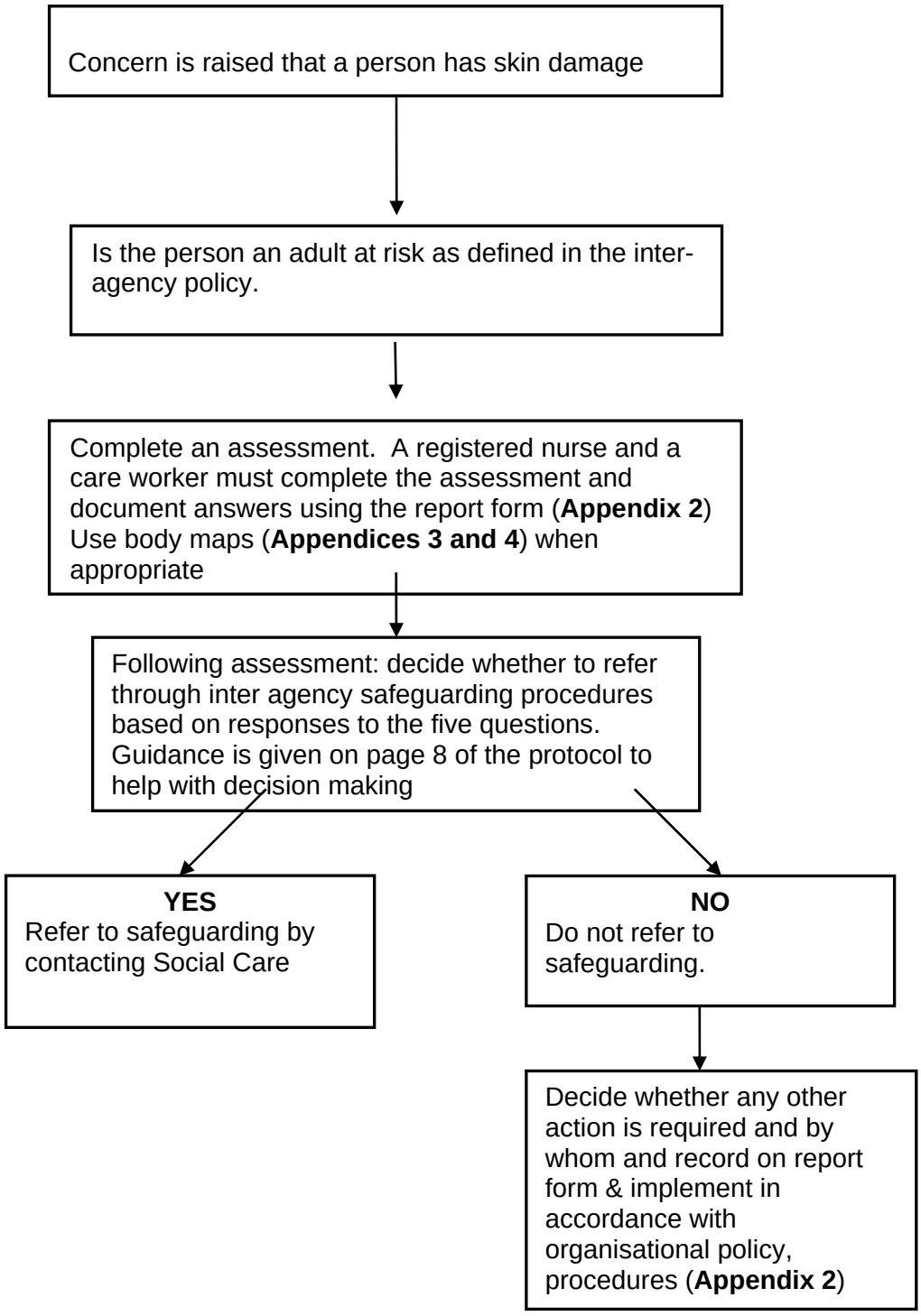
consider whether there is evidence of other forms of abuse. You may wish to use the Risk Support Tool to help you make this decision.

- You should always record your rationale for referring or not referring on the assessment form.

Contributing to an adult safeguarding investigation (Preparation of a report)

If following an adult safeguarding referral to social care, it is determined through the Teeswide adult safeguarding procedures that an investigation is warranted. A report will need to be compiled and submitted to the strategy meeting. A suggested format for this report is attached at **Appendix 5.**

Appendix 1 When should the development of a pressure ulcer (or other skin damage) lead to a referral through the Teeswide Inter-Agency Safeguarding Adults Procedures?



Appendix 2

CONFIDENTIAL

Report to be completed when determining if development of skin damage should lead to a referral through the Teeswide Inter-Agency Safeguarding Adults Procedures

Both assessors must sign this form. One of the assessors **must** be a registered nurse (RGN), and the other a care worker.

The content of this report is confidential. It is part of the Teeswide Inter-Agency Procedures for Safeguarding Adults at Risk and should be shared as part of the procedures. This should be no later than the first strategy meeting.

If after completing this form it is decided that a referral is not required through the Teeswide Inter-Agency Safeguarding Adults procedures then the form should be held within the records the agency has for the person. The agency should determine if further investigation is required and act accordingly.

Name of patient/service user	
Normal address of patient/service user	
DOB	
Hospital Number/NHS number	
Place of current care (if appropriate)	
GP or Consultant	
Brief synopsis	
Report prepared by (Name and Designation)	
At the request of (Name and Designation)	
Date of report	
Purpose of report: ie To establish if neglect has occurred	

Main Findings	
Documentation available at time of reporting (please list these)	

1. Has there been rapid onset and /or deterioration of skin integrity?

Yes ☐ **No** ☐

If yes, describe as objectively as possible and provide details of dates, times of critical events

2. Has there been a recent change in medical condition e.g. infection, pyrexia, anaemia, end of life care, that could have contributed to skin damage?

Yes ☐ **No** ☐

If Yes – please provide brief details below:

Has a reassessment of risk and additional measures been implemented?

Yes ☐ **No** ☐

If Yes – please provide details below:

3 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, but that have not been taken

4 Is the level of damage to skin disproportionate to the patient's risk status for pressure ulcer development? e.g. low risk but extensive injury.

Yes ☐ **No** ☐

If yes please explain:

5 Is there evidence of possible poor practice or neglect?

Yes ☐ **No** ☐

a List evidence seen that poor practice may have contributed to the pressure damage occurring.

b List evidence seen that neglect may have contributed to the pressure damage occurring.

Rationale for referral / non referral:
Refer to section 4 of this form when recording your rationale.

Actions taken

Referral made **Yes** ☐ **No** ☐

If no is there anything else required e.g. referral for specialist equipment, reassessment of need. Detail of who will action these.

If yes also consider whether there is anything else required as well as any immediate action needed or taken to lower risk. Give details of what is required and who will action these.

Details of the two assessors contributing to this assessment

Name:

Job role:

Place of work:

Qualifications:

Signed:

Print Name:

Date:

Name:

Job role:

Place of work:

Qualifications:

Signed:

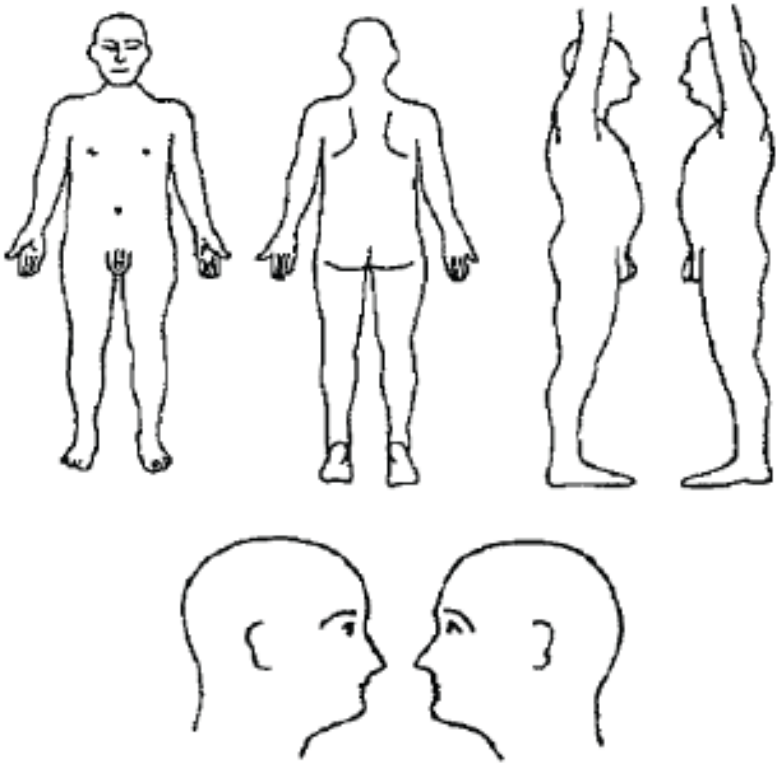
Print Name:

Date:

Appendix 3 Body Maps – male

CONFIDENTIAL

Body maps should be used to record skin damage and can be applied as evidence if necessary at a later date. If two workers observed the skin damage they should both sign the body map.

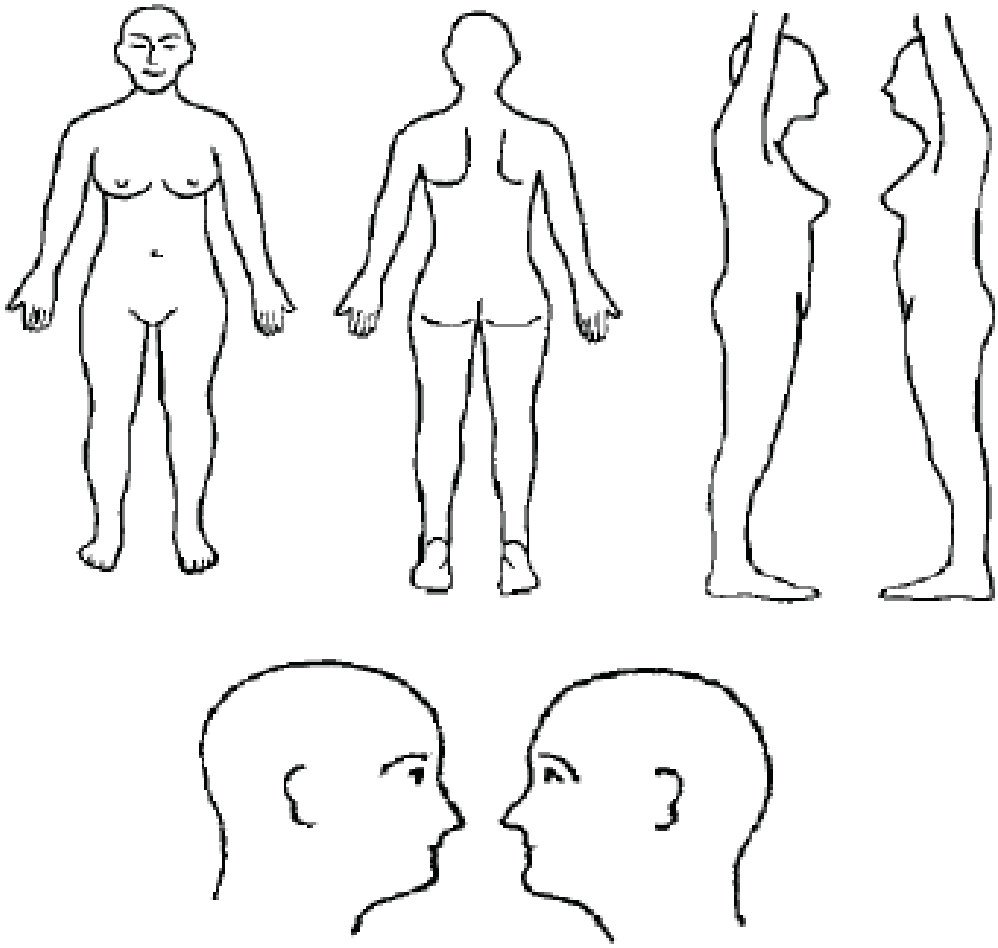


Name of Service User / Patient	
Date of Birth	
Date and time worker(s) witnessed the skin damage	
Name of worker completing body map	
Job Title	
Signature	
Name of second worker witnessing skin damage	
Job Title	
Signature	
Date and time body map completed	

Appendix 4 Body maps – Female

CONFIDENTIAL

Body maps should be used to record skin damage and can be applied as evidence if necessary at a later date. If two workers observed the skin damage they should both sign the body map.



Name of Service User / Patient	
Date of Birth	
Date and time worker(s) witnessed the skin damage	
Name of worker completing body map	
Job Title	
Signature	
Name of second worker witnessing skin damage	
Job Title	
Signature	
Date and time body map completed	

Appendix 5: Suggested Structure for Investigatory Report

When a safeguarding adult's referral is made it will be passed to a lead officer. You may be asked by the lead officer to further investigate the pressure area damage or for further information. Below is the suggested structure for reporting your findings to the lead officer.

Patient History

- Include any factors associated with the patient's behaviour that should be taken into consideration

Medical History

- Does the patient have chronic disease which may impact on skin integrity? e.g. Rheumatoid Arthritis
- Is the patient receiving palliative care?
- Does the patient have any mental health problems which might impact on skin integrity? e.g. dementia / depression

Monitoring of skin integrity

- Should the illness, behaviour or disability of the patient have reasonably required the monitoring of skin condition (where no monitoring has taken place prior to skin damage occurring)?
- The patient's consent to monitoring should always be sought, but if the patient is assessed as lacking the mental capacity to make a decision as to whether monitoring should take place, then the decision should be made in the person's best interests. Although family's views should be sought as part of a best interest decision, they do not have the right to refuse monitoring.
- Did the patient refuse monitoring? If so was the patient assessed as having the mental capacity to refuse such monitoring?
- If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?

Expert advice on skin integrity

- Was appropriate assistance sought and by whom?
- Was advice provided? If so was it followed?

Care Planning and Implementation – skin integrity

- Was a care plan implemented for skin integrity?
- If expert advice was provided was that advice incorporated into a care plan?
- Were all the actions on the care plan implemented? If not, what were the reasons for not adhering to the care plan?