VERSION 1.0

ADULT SAFEGUARDING PRACTICE GUIDANCE

INJURIES OF UNKNOWN ORIGIN

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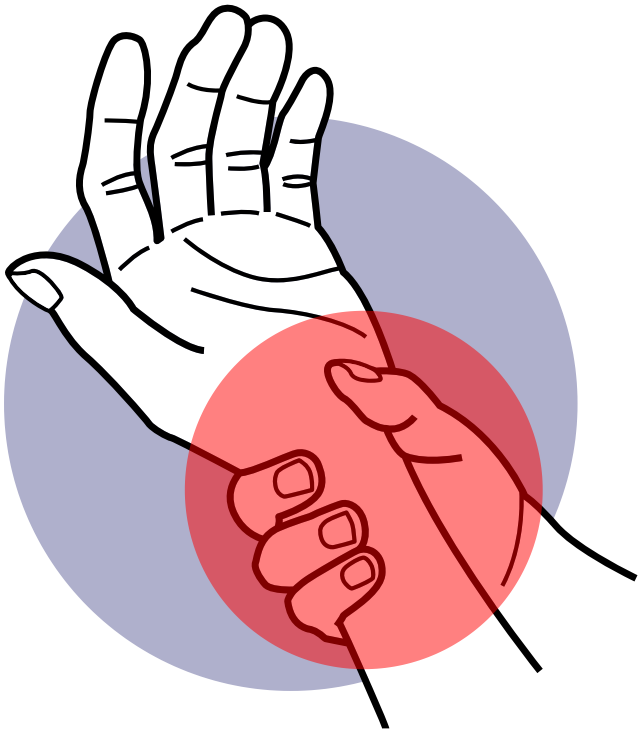
INJURIES OF UNKNOWN ORIGIN

This is a resource to guide professionals and services that have a role in safeguarding. This document provides overarching guidance only and cannot cover specific situations, which should always be discussed with a line manager or the Multi Disciplinary Team (MDT). Injuries of unknown origin should be managed within the National Incident Management Framework, alongside the Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures (2014).

An injury of unknown source is a physical injury that

1. Was not observed
   and/or
2. cannot be immediately and adequately explained



TYPES OF INJURY

This is not an exhaustive list but some types include soft tissue swelling, bruising, burn/scald, print marks, scratches, laceration (broken skin), musculo/skeletal trauma, head injury, fracture, bleeding or other discharge.
Unexplained injuries or marks/bruising of unknown origin can appear for a variety of reasons. These may or may not be related to abusive interactions or safeguarding concerns and can include self-harm and self-injurious behaviours.
Persons with disabilities and older persons should not be prevented from living as full a life as possible and there is clearly no way to prevent people experiencing bruises and scratches in any active or engaged lifestyle. It is important to be mindful of the normative aspirations of older people and people with disabilities i.e. the goal of supporting people to live culturally valued lives not subject to unwarranted restrictions.

Managers should routinely monitor and review data about incidents of unexplained injury. This is particularly important when the service user is the subject of repeated reports to ensure there are sufficient measures in place.—Older/frail service users may be more prone and at greater risk of developing bruising for example if on medications (such as anticoagulants), skin breakdown (as they may have thinner, drier skin), fractures (due to mobility/balance), spontaneous fractures (due to osteoporosis). Careful and ongoing monitoring, including assessing the severity of injury, where on the body the injuries are (using a body map[1]), noting the number of injuries (and whether it is one point in time or over period of time). Equally an adult may experience self-injurious behaviours or engage in self-harm, which requires careful assessment/care planning and communication in order to ensure good practice.[2] Some organisations/services use photographic documentation both for assessment and recording purposes. Please check with your own local policies and procedures regarding the use of photographic recording and ensure that any such documentation is in line with GDPR regulations.

[1] An example of a body map is in appendix 1
[2] Self-injury or self-harm by a service user either intentionally or unintentionally may require a comprehensive multi-disciplinary approach with a positive behavioural plan and psychological/mental health intervention.

TYPES OF INJURY

Services need to be mindful even when taking into consideration the above possible cause of an injury, that such marks, bruising or injuries could be indicative of an abusive interaction especially if supported by any contextual information and/or evidence of other neglect/abuse. It is therefore important that services have robust systems in place to ensure any signs that raise protection concerns or health issues receive attention in a timely manner.

SERVICE RESPONSE

The initial response is to begin screening and gathering all known information to determine the cause. This may include speaking to the service user, all relevant staff, reviewing records and assessing medical information. This can involve a look back at the preceding events the service user was involved in and the environment/context where the service user lives.

1. Services should have an agreed policies and procedure to assess, analyse, monitor and record any injuries of unknown origin on the body of the service user, as part of the overall safeguarding response.
2. All staff members should be aware of such Policy and Procedures.
3. Internal incident management, monitoring and analysis systems should be used to identify if there are patterns to the injuries. Patterns and frequency can be analysed when considering monitoring reports as part of an internal policy. The Service Safeguarding Coordinator should have a key role in this monitoring and analysis process.
4. Particular attention should be paid to any injuries of unknown origin with atypical patterns in the context of the person’s condition, level of frailty, lifestyle or behaviour pattern. Furthermore, there are red flag injuries that would raise particular concern, such as injuries to the thighs and buttocks as this may indicate sexual abuse.

SERVICE RESPONSE

5. The service should have a defined way of recording and tracking such injuries such as undertaking body mapping or charts. The service should endeavour to seek medical assessment where required as soon as possible, as this not only provides necessary treatment, but can act as an independent record.
6. The service should have a developed process for undertaking a medical review and review by a relevant MDT when required. This would be important especially when attempting to come to a team consensus on the actual origin (which might on balance be self-harm and putting in place preventative measures to minimise future risk of injuries of unknown origin. Medical advice is also important when considering medication which is likely to result in easy bruising, or where a person's impairment or condition is susceptible to bruising,
7. A MDT approach is important to devise protective measures in the drafting and co-ordination of any safeguarding plan.

This process will then support the Service Manager, Designated Officer and the MDT in considering any supporting contextual information or evidence to guide them to make an informed decision as to whether the incident warrants the submission of a Preliminary Screening to the HSE Safeguarding and Protection Team.

CASE STUDY

Mary is an adult with severe autism who has extremely limited verbal interactions. Her parents complain to the respite service provider that their daughter has returned from a respite week with unexplained bruising on her lower legs. They say she never has these bruises at home and want the matter investigated.

Her GP assesses the bruising and concludes that the discolouration of the bruising indicates that it probably occurred while she was in respite. He suggests that it looks like she was struck with an implement.

The Designated Officer meets with staff in the respite care facility as well as the MDT of the service.

No incidents were recorded during the week of Mary's stay in respite other than the fact that she was noted to be tearful in the sitting room on Saturday evening. This was attributed to loneliness. However, another service user who also has severe autism and who has had a number of outbursts, was present with Mary in the sitting room on Saturday evening and they were unsupervised for a period of time while staff supervised in the kitchen.

The assessment concluded that it is probable that a safeguarding incident occurred in the sitting room on Saturday evening when the other service user struck Mary (possibly a kick) which was unobserved.

A Preliminary Screening Form is submitted to the Safeguarding and Protection Team. The Safeguarding Plan includes the requirement for service users to be supervised at all times and further training for staff in responding to situations of distress being displayed by service users.

CASE STUDY

John an older man attends his local Community Nursing Unit (CNU) for regular respite care. On his return home from his most recent stay his carers notice bruising to the groin area that was not present prior to admission. The man cannot explain the bruising as he has severe dementia.

The carer informs the Public Health Nurse(PHN) who in turn reports the matter to the CNU. The PHN also advises that the man be brought to his GP for medical assessment.

The Director of Nursing at the CNU carries out an assessment. She concludes that there is no record of an incident involving the man while he was on respite.

All staff who had contact with the man are interviewed but nobody noticed any bruising.

On examination, the GP and PHN agree that the shape of the bruising indicates that a strap of some kind caused the bruising.

It is confirmed that the man was hoisted while in respite care and that the straps used were different from those used at home.

A meeting involving the Quality and Risk Dept., Occupational Therapy Dept. and the Nurse in charge of the unit is convened. It is concluded that that the most likely cause of bruising was the use of different straps.

All staff members are informed of the conclusion and are asked to be vigilant in their application of equipment.

Straps similar to those used in the man’s home are provided to the ward for future use.

The outcome in this preliminary screening was no grounds for concern, lessons learned.

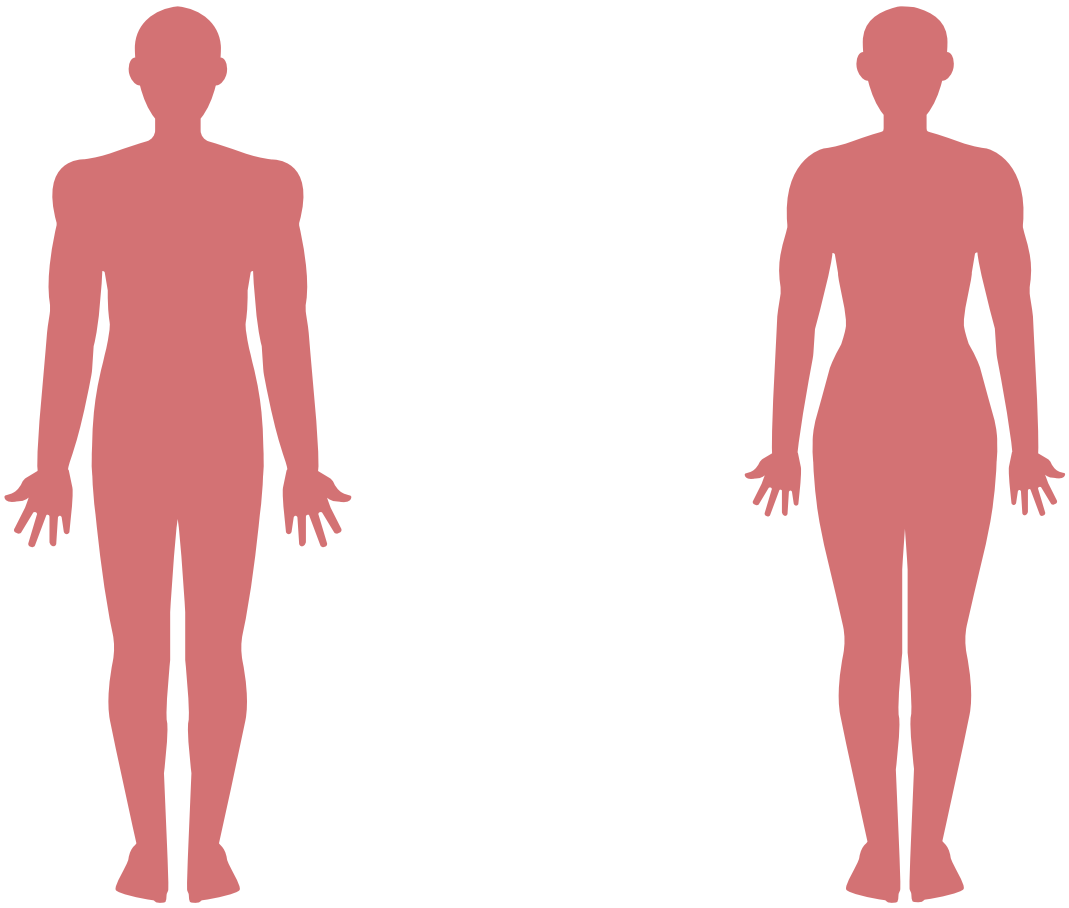
CASE STUDY

Joe is a young adult with an intellectual disability and he regularly engages in self-injurious behaviour. There is a care plan in place which requires staff to redirect Joe when he does this, so as to minimise the harm. Amy, a student nurse, starts her shift and finds Joe with a scratch on his arm and face. She asks Joe how it happened but Joe cannot tell her. Amy alerts the nurse in charge who shows Amy that this was recorded in Joe's notes as being caused by a self-injurious behaviour, that the staff had activated the plan to redirect Joe once he began self-harming.

In this case there is no requirement to complete a Preliminary Screening.

Appendix 1

BODY MAP



This is an example of a body map/chart but there are many others available. The body map/chart is not intended to replace your recording of the injury, and must be used in addition to an accurate detailed account of all the information gathered pertaining to the injury.

Appendix 2

Unexplained Injury Flow Chart

Staff should consider the following on discovery of an unexplained injury.

1. Provide any immediate care required for the injury
2. Provide reassurance to the service user and ask what happened.
3. Review the service users notes and behaviour records.
4. Consider the service users overall health status including physical and mental well being, current medications, and any changes to physical environment.
5. Gather any relevant information from staff or others.

If any probable explanation can be established following consideration of the above staff should:

1. Complete body map
2. Complete NIMS and safeguarding preliminary screening where appropriate
3. In consultation with the MDT update any plans as required , in light of any changes

If a probable explanation cannot be established following the review staff should:

1.Complete body map
2. complete NIMS
3.Refer to safeguarding
4.Refer to HIQA if applicable