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Case Report

How Well Do We Achieve SAFER Referrals?

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ABSTRACT

Aims: Assess the completion of Situation, Assessment, Family, Expected Response, and Recording (SAFER) referrals for paediatric dog bites under 5yrs, and burns with clinical suspicion at a trauma centre. It is a document used to communicate concern with the LSCB (Local Safeguarding Children's Board).

Method: Data was collated from e-records and case notes during 1/1/18-30/10/2018. The LSCB and hospital safeguarding team do not hold databases with information regarding these referrals.

Results: 81 were seen by Plastic Surgery with dog bites. 33 were children (40.74%). 18/81 were 5yrs or less at presentation (22.2%); 8/18 referrals were completed (44.4%). For one a referral was deemed inappropriate because the bite was sustained from a stranger's dog. 164 paediatric burns were reviewed. 7/164 (4.3%) raised suspicion and 6/7 had referrals (85.7%).

Discussion: Fewer referrals were made for dog bites. Possibly due to lack of awareness of guidelines, poor availability of forms or ambiguity regarding responsibility. Referrals sent for burns were better perhaps because of a perceived greater risk assigned to this injury or because the workload was monitored by a single clinical lead with knowledge of the pathway. Data collection was difficult due to multiple recording methods, which may cause clinical errors. Solutions could include staff education, clear guidelines within departments with easy access to forms, or added checklists.

Conclusion: Referrals were not completed often enough with several areas of improvement. There are easy steps that can be implemented which could lead to increased effectiveness of our communication and standard of care.

Background

Ensuring the safety of children is an integral goal for the NHS, and South Tees Hospitals NHS Foundation Trust (STHFT). This provision of surveillance and care in the secondary setting must be reflected to an equally high standard in the community, and to achieve this effective communication between teams involved is needed. A safer referral (Situation, Assessment, Family, Expected Response, and Recording Referral) is a document utilized throughout South Tees University Hospitals NHS Foundation Trust (STHFT), to achieve wider patient support under the Tees LSCB (Local Safeguarding Children's Board) or First Contact Multi-agency [1, 2]. This channel of communication allows concerns from health care practitioners to be heard within the community services responsible for overlooking those children at risk. Incorrect or incomplete referrals can result in significant delay in managing the source of a problem leaving a child or other individuals at risk. Several factors may affect the efficacy of referral completion and execution, for example: Who is completing the referral, and have they informed the parent health care team? Are the teams aware that a SAFER form should be completed? Is information and the form easily accessible and clear? Has the form been correctly completed for the appropriate reasons? For example, referrals have been completed in the past concerning the parents of a child arguing but not for the bite injury. There are circumstances in which it is difficult to enforce a solution, for example if the dog belongs to an unknown member of the community.

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Objective

To assess the completion of SAFER referrals for children under the age of 5 with dog bites sustained from a family owned dog, or for children with clinically suspicious burns.

Guidelines

"A referral to children's social care following the Tees LSCB procedures should be made if there is any evidence that a dog has caused injury to a child which has required medical treatment or any injury to a child under the age of 5 years" [3].A SAFER referral is prompted if a child attended medical services and has sustained burn injuries with clinical suspicion and safeguarding concerns [4].

Method

A retrospective analysis was made of the correct and appropriate submission of SAFER referrals throughout the period of 1/1/18→31/10/18 at STHFT within the Plastic Surgery and Emergency Departments for children aged 5 years or less with dog bites and paediatric burns with clinical suspicion. Data was collected from PAT (Plastic Surgery Audit Tool), Evolve (paediatric electronic records system), Symphony (Emergency Department electronic records system), the Plastic Surgery burns database, and individual patient's notes. Following each inquiry, neither First Contact Middlesbrough nor the Safeguarding team at STHFT kept formal databases of safer referrals completed for these patient groups. This is due to replacement of the child protection register with child protection plans throughout England in 2008 [5, 6].

Location of Bite	**Face**	**Other**
	17 (94.4%) (ONE FACE&LEG)	2 (11.1%) (ONE THIGH AND CHEST WALL)

OWNER OF DOG	**FAMILY/FRIEND**	**Stranger's**	**No documentation**
	10	1	7

SAFER REFERRAL	**Completed**	**Unknown/no documentation**
	Total: 8 PAT: 2 Symphony: 3 Evolve: 2 Notes: 1	Total: 10 1 stated intent to complete form, however no form was found.

SAFER REFERRAL	**Completed**	**Unknown/no documentation**
	Total: 6 Symphony: 3 Evolve: 1 Both: 2	Total: 1

Another audit regarding SAFER referrals was previously completed looking specifically at accident and emergency over the past year; however, it encompassed all animal bites in children and did not highlight those under the age of 5.

Results

During the period of the 1st of January 2018 to the 31st of October 2018, 81 patients were seen within the plastic surgery department at STHFT with dog bites. 33 of these were in children (40.74%). 18 were 5 years old or less at their presentation to medical services (22.2%). 8 out of this 18 had SAFER referrals completed (44.4%). The majority of dog bites to children of this age group were facial injuries. During 2018, 164 children with burns were reviewed by the Plastic Surgery team. Out of these, 7 (4.3%) raised clinical suspicion and 6 had SAFER referral forms completed (85.7%).

Discussion

8 dog bite SAFER referral forms were correctly completed with an appropriate reason for the referral, demonstrating that those completing the forms had a good understanding of the intended outcome of the forms and their use. Referrals for suspicious burns in our series were better, although the sample size for burns patients was smaller. This may be because of a perceived greater risk assigned to the injury by the health care professional compared to the dog bites in our series or because the burns workload was overseen by a single clinical lead who was aware of the referral pathway. Whilst dog bites may not have been directly intended by the child's guardian, the child had still sustained an injury requiring medical intervention and the guidelines have reflected this. It is also important to note, that whist there are statutory requirements and highly important cases in which healthcare professionals should disclose information to the police, no such recommendation has been made for paediatric dog attacks [7]. At STHFT there are fortnightly burn MDT meetings, at which healthcare professionals from ED, safeguarding and plastics attend, to discuss patients who have been logged onto a burns database. Supervision of this patient group, with senior colleagues continuing to promote correct management, provides a safety net for this cohort, which could explain why the majority of SAFER referrals have been completed [10]. Several factors may have resulted in poor compliance with this guideline. Perhaps the most important, is lack of awareness of healthcare professionals. Information is available within the A&E department for the management of dog bites; however, it does not clearly state that it is necessary for one to be completed for those under the age of 5. Nor does it specify which health care professional is

responsible for completing this form or which form is required. Human error and lack of awareness may contribute to less complete management of an at-risk patient demographic through the lack of SAFER referral completion. Responsibility was also not allocated to a specific team, increasing ambiguity. Communication is an integral part of the healthcare system and it is necessary to make hospital staff aware to facilitate continuation of care in the wider setting. Information is available within the STHFT Plastic Surgery junior doctor's handbook which is easily accessible on the STHFT intranet and trainee doctors within the department are encouraged to read it at their induction, improving awareness of necessary management. One dog bite resulted from a stranger's dog, and it was agreed that in this instance referring to safeguarding services would be inappropriate. The objective of completing a referral is to assess the danger of a child's environment and prevent future events occurring. Alerting social services to an unknown dog in a public setting would have no effect upon the child's level of safety. Gathering information for this study was challenging due to the involvement of several documentation systems including electronic and written formats. STHFT has at least 4 EPR systems that the authors are aware of and these systems don't easily link together. This can lead to poor communication between departments and lack of continuity of care. For example, 2 dog bite referrals were completed by the Paediatric team rather than A&E after they had noticed there was no safeguarding form recorded for the children. This is a positive response and demonstrates a high standard of care, however a presumption could also have been made vice versa whereby due to the separate computer systems, the lack of documentation was overlooked with the understanding that the responsibility perhaps lies with A&E. Furthermore, the low number of SAFER referrals found may not be an accurate representation of the total, if documentation and written communication is poor.

Potential Solutions

1) Appoint a singular team to be responsible for the completion of the form
    a. There would be less ambiguity within different departments and fewer children being missed.
    b. It would allow the referrals to be clearly documented on one system, therefore making data retrieval and communication much easier, leaving less opportunity for human error.
    c. This would however not be in keeping with the ethos that the responsibility for patient safety and care, lies with all members of staff.
    d. There may be issues over General Data Protection as of new guidelines from May 2018.
2) The referral should be done at a specific point in the patient care timeline. The logical place for this is at the first point of entry of the child into the system, likely A&E. Subsequent follow up of this can then be highlighted to ongoing referral teams.
3) Introduce a 'tick box' system to databases such as PAT and symphony, as well as history sheets highlighting consideration for referrals.
4) Trust wide and departmental induction teaching should be made available, regarding what constitutes an appropriate SAFER referral, and for which patient demographic it is required for.
    a. This could be incorporated into an induction day within departments
    b. This would raise awareness, allowing individuals to voice their concerns if they do not understand the protocol.
5) Ensure that these guidelines are easily accessible for members of staff
    a. This could be achieved by clearer documentation on the Intranet, or by placing posters within specific areas of A&E for example, the nurses station or See and Treat.
6) Raise awareness of the value of medical photography in these cases, to provide further evidence for these instances if required, although accessing medical photography presents its own problems.
7) Consider a formal database of dog bite injuries in those patients under 5years old (similar to our burns database) which can be reviewed for submission of referrals by the trust.
8) The safeguarding team should keep a database of all referrals, from whatever source.

Conclusion

SAFER referrals were not completed often enough for paediatric patients in this series, with several areas identified for improvement. There are easy steps that can be implemented, which could lead to a significant increase in the effectiveness of our communication and standard of care for this patient demographic, in the wider setting.

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