Department of Health & Social Care

Appendices: adult safeguarding decision guide, body map and concern proforma

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Contents

Appendix 1: adult safeguarding decision guide

You should review all 6 questions and see the score conclusion.

Patient information

Patient name:

Patient number:

Assessor information

Assessing nurse’s name (print):

Job title:

Assessing nurse’s signature:

Second assessor’s name (print):

Job title:

Second assessor’s signature:

Question 1

Has the patient or service user's skin deteriorated to either category 3, 4 or unstageable, or multiple sites of category 2 ulceration from healthy unbroken skin, since the last opportunity to assess or visit?

Level of concern	Score	Evidence
Yes For example, record of blanching or non-blanching erythema or grade 2 progressing to grade 2 or more	5	For example, evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
No For example, no previous skin integrity issues or no previous contact health or social care services	0	

Question 2

Has there been a recent change, that is within days or hours, in their clinical condition that could have contributed to skin damage?

For example, infection, pyrexia, anaemia, end of life care or critical illness.

Level of concern	Score	Evidence
Change in condition contributing to skin damage	0	
No change in condition that could contribute to skin damage	5	

Question 3

Was there a pressure ulcer risk assessment or reassessment with an appropriate pressure ulcer care plan in place, and was this documented in line with the organisation's policy and guidance?

Level of concern	Score	Evidence
Yes, current risk assessment and care plan carried out by a healthcare professional and documented appropriate to patient's needs	0	State date of assessment, risk tool used and score or risk level
Yes, risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	State the elements of care plan that are in place
No or incomplete risk assessment and/or care plan carried out	15	State the elements that would have been expected to be in place but were not

Question 4

Is there a concern that the pressure ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services?

Level of concern	Score	Evidence
No, or not applicable	0	
Yes	15	

Question 5

Is the level of damage to skin inconsistent with the or service user's risk status for pressure ulcer development?

For example, low risk, category (or grade) 3 or 4 pressure ulcer.

Level of concern	Score	Evidence
Skin damage less severe than patient's risk assessment suggests is proportional	0	
Skin damage more severe than patient's risk assessment suggests is proportional	10	

Question 6

Question 6 has 2 parts depending on the patient or service user:

- if the patient or service user has capacity to consent to every element of the care plan, answer question 6a
- if the patient or service user has been assessed as not having mental capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan, answer 6b

Question 6a

Was the patient or service user able to follow the care plan having received clear information regarding the risks of not doing so?

Level of concern	Score	Evidence
Patient has not followed care plan and local non concordance policies have been followed	0	
Patient followed some aspects of care plan but not all	3	
Patient has not followed care plan or not given information to enable them to make an informed choice	5	

Question 6b

Was appropriate care undertaken in the patient's best interests, following the best interests checklist in the Mental Capacity Act Code of Practice?

This should be supported by documentation, for example, capacity and best interest statements and record of care delivered.

Level of concern	Score	Evidence
Documentation of care being undertaken in patient's best interests	0	
No documentation of care being undertaken in patient's best interests	10	

Score conclusion

If the total score is 15 or over, discuss with the local authority (safeguarding) as determined by local procedures and reflecting the urgency of the situation.

When the decision guide has been completed, even when there is no indication that a safeguarding alert needs to be raised, the tool should be stored in the patient's notes.

Appendix 2: body map

Body maps should be used to record skin damage and can be applied as evidence, if necessary, at a later date.

If 2 workers observed the skin damage, they should both sign the body map.

Patient information

Patient name:

Patient number:

Assessor information

Assessing nurse’s name (print):

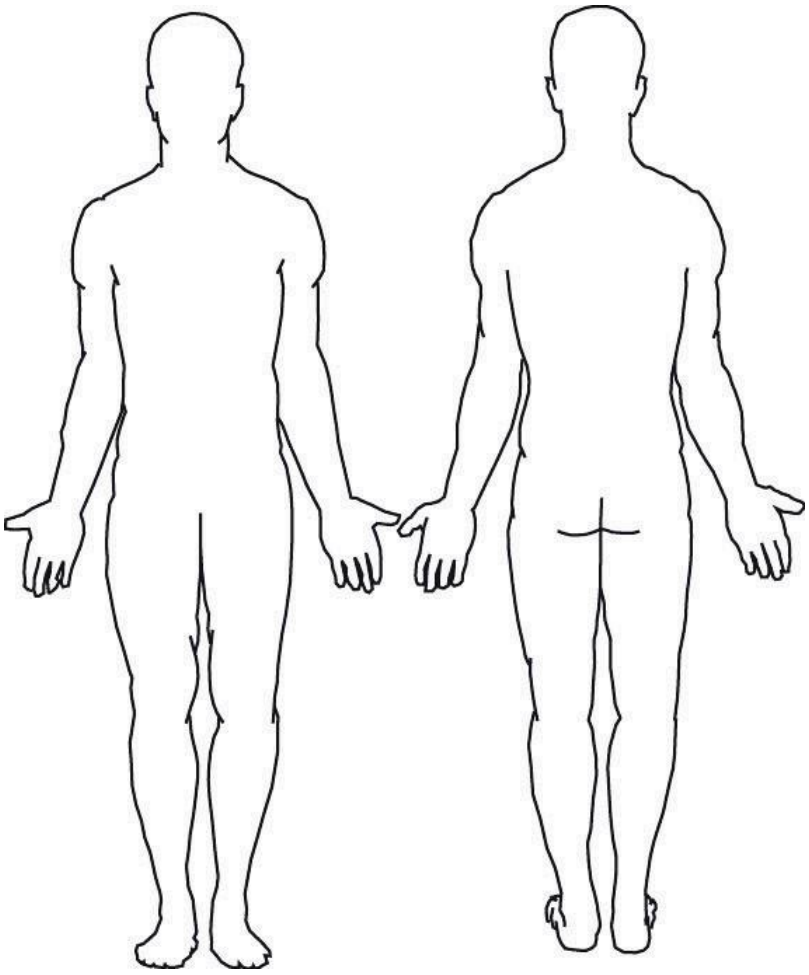
Job title:

Assessing nurse’s signature:

Second assessor’s name (print):

Job title:

Second assessor’s signature:



Appendix 3: adult safeguarding concern proforma regarding pressure ulceration

Fill this form in if the assessment guide score is 15 or over.

Patient information

First name:

Last name:

Date of birth:

NHS number:

Address:

Assessor information

Department or base address:

Organisation name:

Telephone number:

Assessing nurse’s name (print):

Job title:

Assessing nurse’s signature:

Second assessor’s name (print):

Job title:

Second assessor’s signature:

Date and time assessors witnessed pressure ulceration:

Date and time of completing documentation of concern:

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