# Appendices 1 to 3: adult safeguarding decision guide, body map and concern proforma

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## Appendix 1: adult safeguarding decision guide

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

### Person's information

Person's name:

Person's NHS number:

### Assessor information

Assessing nurse’s name (print):

Job title:

Assessing nurse’s signature:

Note: when using an electronic patient record (EPR), this guide will be completed under one assessor's profile. However, if there is a second assessor present, you should record their name.

Second assessor’s name (print):

Job title:

Second assessor’s signature:

### Question 1

Has the person's skin deteriorated to either category 3 or 4 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 progressing to category 2 or category 2 progressing to category 3 or 4 | 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 (skin changes at life end), critical illness, emergency hospital visit.

|  |  |  |
| --- | --- | --- |
| 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 person's needs  If the person is not under the care of a healthcare professional, the carer responsible has screened for risk and implemented preventative care accordingly | 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 person's risk status for pressure ulcer development?

For example, no risk factors that align with the category of pressure ulcer that has developed.

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

### Question 6

Question 6 has 2 parts - which part you ask depends on the person:

* if the person has capacity to consent to every relevant element of the care plan, answer question 6a
* if the person has been assessed as not having mental capacity to consent to any or some relevant aspects of the care plan, answer 6b

#### Question 6a

Were the risks and benefits explained and understood by the person?

Was a plan of care agreed in line with shared decision making and has the person chosen to follow the relevant aspects of the plan?

|  |  |  |
| --- | --- | --- |
| Level of concern | Score | Evidence |
| Person has followed care plan, and local policies to support shared decision making have been followed | 0 |  |
| Person followed some aspects of care plan but not all | 3 |  |
| Person has not followed care plan or not given information to enable them to make an informed choice, or an opportunity to discuss reasons for not following the agreed plan and alter the plan accordingly has not been taken | 5 |  |

#### Question 6b

Was the relevant care undertaken in the person's best interests, following the best interests checklist in the Mental Capacity Act?

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 person’s best interests | 0 |  |
| No documentation of care being undertaken in person’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 person'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.

### Person's information

Person's name:

Person's NHS number:

### Assessor information

Assessing nurse’s name (print):

Job title:

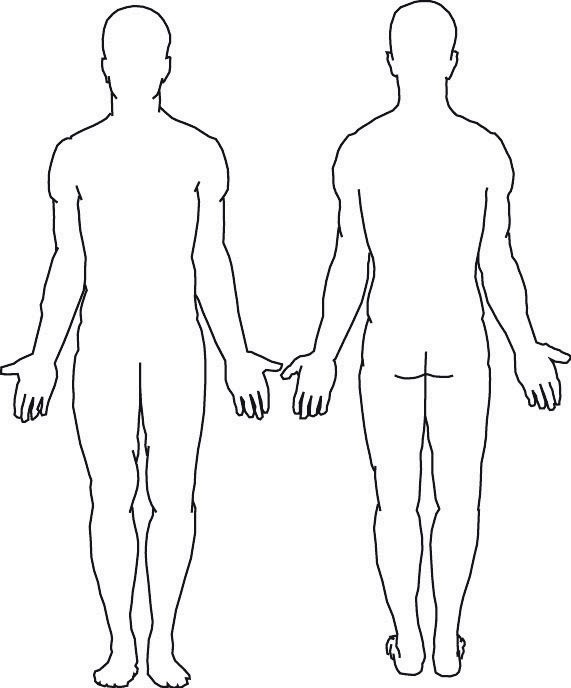
Assessing nurse’s signature:

Note: when using an electronic patient record (EPR), this guide will be completed under one assessor's profile. However, if there is a second assessor present, you should record their name.

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 adult safeguarding decision guide score is 15 or over.

### Person's 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:

Note: when using an electronic patient record (EPR), this guide will be completed under one assessor's profile. However, if there is a second assessor present, you should record their name.

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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