

### Appendix 3: Adult Safeguarding Decision Guide for individuals with severe pressure ulcers

Q	Risk Category	Level of Concern	Score	Evidence
1	Has the patient's skin deteriorated to either grade 3/4/ unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/ visit	Yes e.g. record of blanching / non-blanching erythema /grade 2 progressing to grade 2 or more	5	E.g. evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
		No e.g. no previous skin integrity issues or no previous contact health or social care services	0	
2	Has there been a recent change, i.e. within days or hours, in their / clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anemia, end of life care, critical illness	Change in condition contributing to skin damage	0	
		No change in condition that could contribute to skin damage	5	
3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	0	State date of assessment Risk tool used Score / Risk level

		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	What elements of care plan are in place
		No or incomplete risk assessment and/or care plan carried out	15	What elements would have been expected to be in place but were not
4	Is there a concern that the Pressure Ulcer developed as a result of the informal carer willfully ignoring or preventing access to care or services	No / Not applicable	0	
		Yes	15	
5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk—Category/grade 3 or 4 pressure ulcer	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	
6	Answer (a) if your patient has capacity to consent to every element of the care plan. Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan.			
a	Was the patient compliant with the care plan having received information	Patient has not followed care plan and local non	0	

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	regarding the risks of non-compliance?	concordance policies have been followed.		
		Patient followed some aspects of care plan but not all	3	
		Patient followed care plan or not given information to enable them to make an informed choice.	5	
b	Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice? (supported by documentation, e.g. capacity and best interest statements and record of care delivered)	Documentation of care being undertaken in patient's best interests	0	
		No documentation of care being undertaken in patient's best interests	10	
TOTAL SCORE				

If the 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.

Patient Name: .....

Patient No:.....

Name of assessing nurse (PRINT)			
Job Title		Signature	
Name of second assessor (PRINT)			