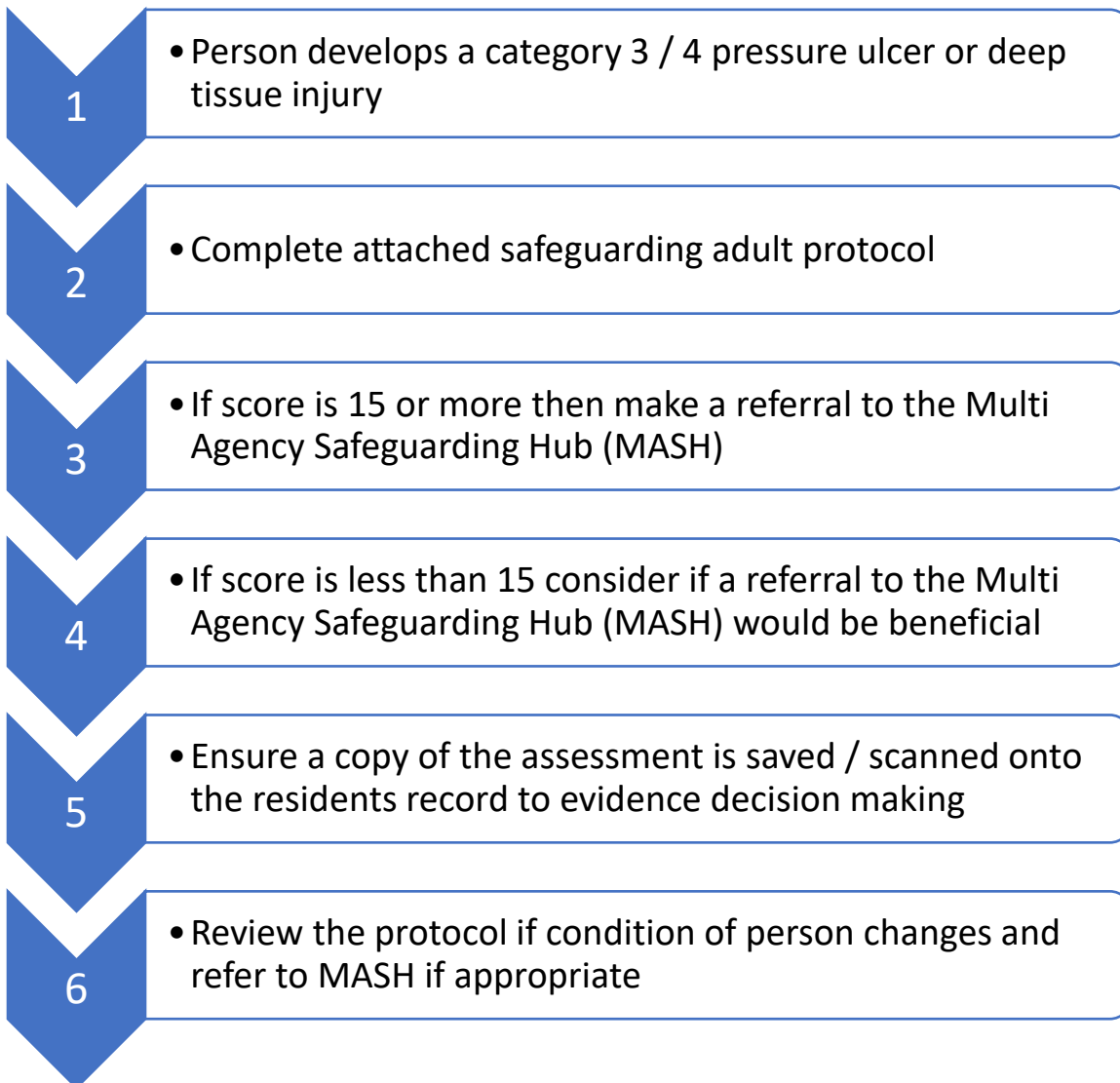




## Adult Safeguarding Decision guide for Individuals with severe pressure ulcers eg Category 3 / 4 or Deep tissue injury



Question	Risk Category	Level of concern	Score	Evidence
1	Has the resident'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 / nonblanching erythema	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
4	Is there a concern that the Pressure Ulcer developed as a result of the informal carer wilful 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 resident's risk assessment suggests is proportional	0	
		Skin damage more severe than resident's risk	10	

		assessment suggests is proportional		
6	Answer (a) if your resident has capacity to consent to every element of the care plan. Answer (b) if your resident 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 resident compliant with the care plan having received information regarding the risks of non-compliance?	Resident has not followed care plan and local non-concordance policies have been followed	0	
		Resident followed some aspects of care plan but not all	3	
		Resident followed care plan or not given information to enable them to make an informed choice	5	
b	Was appropriate care undertaken in the resident'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 resident's best interests	0	
		No documentation of care being undertaken in resident'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 resident's notes**

The decision guide should be reviewed if the residents condition changes and consideration be given if a referral to safeguarding is required

Referrals to safeguarding to be made as follows:

Nottinghamshire County [Multi-Agency Safeguarding Hub \(MASH\) | Nottinghamshire County Council](#)

Nottingham City Council [Safeguarding Adults - Nottingham City Council](#)

References: