HALTON BOROUGH COUNCIL

SAFEGUARDING ADULTS BASELINE ASSESSMENT

SECTION 1: Personal Details

<table>
<tr><td colspan="4">Name of Vulnerable Person:</td></tr>
<tr><td>Date of Birth:</td><td>Gender:</td><td colspan="2"></td></tr>
<tr><td colspan="2">Address:

Post Code:
Telephone No:</td><td colspan="2">GP Details:</td></tr>
<tr><td>Name of person who identified the concern in the first place:</td><td colspan="2">Address:</td><td>Telephone No:</td></tr>
<tr><td colspan="4">Brief Factual Description of Allegation(s), including dates of referral(s) to HBC:

Referral Date: Allocation Date:</td></tr>
<tr><td colspan="4">Is alleged victim known to Halton Adult Social Services at time of referral?
Yes No</td></tr>
<tr><td colspan="4">Number of previous referrals of abuse of this vulnerable adult ☐</td></tr>
<tr><td colspan="4">Alleged Perpetrator(s) (if known)</td></tr>
<tr><td colspan="3">Are there any contractual issues? Yes ☐ No ☐

If contractual issue(s) involved in the case, provider monitoring form(s) must be completed and sent to Social Services Contracts Section (and attached).</td><td>Date(s) sent:

By Whom:</td></tr>
<tr><td colspan="2">Do any of the allegations meet PPU/General Police criteria</td><td colspan="2">Yes ☐ No ☐</td></tr>
<tr><td colspan="4">If a referral was made to the Police gice CAVA/Police reference/or crime number ☐</td></tr>
</table>

NAME	Carefirst ID

SECTION 2 – Care Provision

Name of Care Provider:	
Address: Post Code: Telephone No:	Care Provision:
Care Commissioned and Funded By: Commissioners of Care aware of Safeguarding Concern Date By Whom	
Past Medical History and Prognosis if Known:	

NAME	Carefirst ID

PERSONAL CARE **Washing & Dressing**	Independent ☐ Supervision/Assistance of 1 carer ☐ Dependent on 2 carers ☐ Care Plan Yes No N/A Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
Comments	

Skin Care (attach pressure ulcer risk assessment where available) Pressure Ulcer Score ☐ Please state tool used and risk score: Pressure ulcers/wounds Yes No If Yes state site, size and dressings in use as evidenced in care provider records in comments below Pressure ulcer/wound assessment chart in place Yes No **Tissue Viability Team involvement** Yes No Date assessed: Treatment plan/advice evident in care plan Yes No Date discharged: Referral required Yes No Pressure relieving equipment in use Yes No Pressure area care maintained eg turn chart Yes No Care Plan Yes No N/A Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
Comments

NAME	Carefirst ID

Foot Care

Any problems with feet or nails Yes No

Podiatrist involvement Yes No

Date assessed:

Treatment plan/advice evident in care plan Yes No

Date discharged:

Referral required Yes No

Care Plan Yes No N/A

Care Plan Last Updated:

Safeguarding Concerns Identified/Substantiated Yes No

If Yes please identify in comments below

Comments

NUTRITION

Independent/Supervision ☐ Dependent ☐

Nil by Mouth/Artificial Feeding ☐

Fortified diet Yes No

Supplementary feeding Yes No

Weight ☐ Weight loss/identify amount ☐

If unable to weigh, state reason

Alternative measures in place – state

Special dietary requirements (please state):

Nutritional score ☐ Risk Level Low ☐ Medium ☐ High ☐ BMI Score ☐

Nutritional Tool Used:

Food chart in use Yes No

Dietician involvement Yes No

Date assessed:

Treatment plan/advice evident in care plan Yes No

NAME	Carefirst ID

Date discharged:

Referral required Yes No

Speech and Language Therapist Involvement Yes No

Date assessed:

Treatment plan/advice evident in care plan Yes No

Date discharged:

Referral required Yes No

Care Plan Yes No N/A

Care Plan Last Updated:

Safeguarding Concerns Identified/Substantiated Yes No

If Yes please identify in comments below

Comments

HYDRATION Independent/Supervision for fluids ☐

Dependent for fluids ☐

Intake/output chart required Yes No

Care Plan Yes No N/A

Care Plan Last Updated:

Safeguarding Concerns Identified/Substantiated Yes No

If Yes please identify in comments below

Comments

MEDICATION Independent ☐ Supervision/assistance ☐

Concordant ☐ Non Concordant ☐

Medication administered covertly Yes No If Yes is this in accordance with covert medication policy guidelines? Yes No

Special requirements eg Syringe Driver ☐

Care Plan Yes No N/A

Care Plan Last Updated:

Safeguarding Concerns Identified/ Substantiated Yes No

If Yes please identify in comments below

NAME	Carefirst ID

MEDICATION (Please attach current copy of MARS sheet where available)
List All Medication
Known allergies:
Comments
PAIN – symptom control eg pain, nausea, vomiting, agitation Symptoms controlled Yes No If No please identify in comments below **Regular Specialist Nurse/Clinician/Therapist intervention Involvement** Yes No If Yes please specify: Date assessed: Treatment plan/advice evident in care plan Yes No Date discharged: Referral required Yes No Care Plan Yes No N/A Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
Comments
HEARING and VISION Normal ☐ Impaired ☐ Aids Used ☐ Care Plan Yes No N/A

NAME	Carefirst ID

	Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
Comments	
COMMUNICATION	Normal ☐ Impaired ☐ Able to Indicate Needs Yes No Uses alternate communication Yes No If Yes please identify in comments below **Speech and Language Therapist Involvement** Yes No Date assessed: Treatment plan/advice evident in care plan Yes No Date discharged: Referral required Yes No Care Plan Yes No N/A (please circle) Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
Comments	

BREATHING

Difficulty with breathing Yes No If Yes please identify in comments below

Are any of the following required to aid breathing: Please tick where appropriate

Oxygen	☐	Nebuliser	☐	Inhaler	☐
Tracheostomy	☐	Suction	☐	Ventilator	☐

Other: please state:

Regular Specialist Nurse/Clinician/Therapist intervention Involvement Yes No

If Yes please specify:

Date assessed:

Treatment plan/advice evident in care plan Yes No

NAME	Carefirst ID

Date discharged: Referral required Yes No Care Plan Yes No N/A Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
Comments
ELIMINATION Bladder Continent ☐ Catheter/conveen ☐ Incontinent ☐ Occasional ☐ Day ☐ Night ☐ Bowels Continent ☐ Stoma ☐ Incontinent ☐ Occasional ☐ Day ☐ Night ☐
Frequency of toileting
Bladder/ bowel problems, eg UTI, constipation: please state
Continence aids used: please state
Continence assessment completed Yes No Date assessed: Treatment plan/advice evident in care plan Yes No Date discharged: Referral required Yes No Care Plan Yes No N/A Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
Comments

NAME	Carefirst ID

MOBILITY	Independent ☐ Supervision/assistance of one carer ☐ Dependent on two carers ☐ Aids/equipment required for moving and handling Yes No If Yes please specify in comments below Moving and Handling Risk Assessment completed Yes No If No is an assessment required Yes No **Pysiotherapist/ Occupational Therapist Involvement** Date assessed: Treatment plan/advice evident in care plan Yes No Date discharged: Referral required Yes No Care Plan Yes No N/A Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
	History of falls Yes No Falls Risk Assessment Completed Yes No **Falls Co-ordinator Involvement** Yes No Date assessed: Treatment plan/advice evident in care plan Yes No Date discharged: Referral required Yes No Care Plan Yes No N/A Care Plan Last Updated: Safeguarding Concerns Identified/Substantiated Yes No If Yes please identify in comments below
Comments	

NAME	Carefirst ID

MENTAL HEALTH – Memory/Cognition

No memory loss ☐ Short term memory loss ☐

Long term memory loss ☐ Occasionally forgetful/needs prompting ☐

Orientated/disorientated ☐ Confused/wandering ☐

Decision-Making

Have there been concerns with regards to specific decision-making Yes No If Yes please specify in the comments below

Have the Mental Capacity Act Guidelines been followed Yes No

Is this evidenced in the care records Yes No

Psychiatrist Involvement Yes No

Date assessed:

Treatment plan/advice evident in care plan Yes No

Date discharged:

Referral required Yes No

Care Plan Yes No N/A

Care Plan Last Updated:

Safeguarding Concerns Identified/Substantiated Yes No

If Yes please identify in comments below

Comments

PSYCHOLOGICAL FEATURES

Mood appears stable ☐ Mood appears changeable ☐

Low mood/depressive illness ☐ Episodes of tearfulness/distress ☐

Episodes of anxiety ☐ Risk of self harm ☐

Experiences hallucinations/delusions ☐

Psychiatrist/Mental Health Services Involvement Yes No

Date assessed:

Treatment plan/advice evident in care plan Yes No

Date discharged:

Referral required Yes No

NAME	Carefirst ID

Care Plan Yes No N/A

Care Plan Last Updated:

Safeguarding Concerns Identified/Substantiated Yes No

If Yes please identify in comments below

Comments

Behaviour

Even tempered and consistent ☐ Occasionally agitated/easily resolved ☐

Regularly agitated/easily resolved ☐ Constantly agitated/requiring intensive support ☐

Unusual/disinhibited behaviour ☐

Any identified triggers for identified behaviours Yes No If Yes please specify in comments below and detail what action has been taken

Psychiatrist/Mental Health Services Involvement Yes No

Date assessed:

Treatment plan/advice evident in care plan Yes No

Date discharged:

Referral required Yes No

Care Plan Yes No N/A

Care Plan Last Updated:

Safeguarding Concerns Identified/Substantiated Yes No

If Yes please identify in comments below

Comments

NAME	**Carefirst ID**

PROFESSIONAL VISITS		
Date	Reason for Visit	Outcome
Is a review by the GP required now? YES/NO		
If Yes please specify why a review is required:		

NAME	Carefirst ID

Summary of Assessment/Recommendations/General Observations
NAME OF ASSESSOR
SIGNATURE OF ASSESSOR
DATE