B2 Body Map

Version: New

Date: 01/04/23

Extra Care Housing Servce	Support at Home Service	OA Day Services	Residential Services	DMH Day Services	DMH Supported Living Services	Community Equipment Services	Shared Lives Service
✓	✓	✓	✓	✓	✓	X	X

Policy

To take all necessary and appropriate action to safeguard the Service User, by identifying, recording and describing all signs of injury or breakdown of skin integrity and reporting and monitoring any deterioration or improvement.

Procedure

1. Each Service User, at the point of admission, should have a Body Map Appendix 1, within their Person Centred Care Plan (PCCP) and numbered as sheet 1.

2. As part of the initial admission procedure the body map must be completed to record any marks, bruising, redness, or anything out of the ordinary on the day of admission.

Filling in the body map.

- Start as Sheet 1
- Complete the establishment name
- Add in the unit details if applicable
- Put in the date that the form has 1st been started
- Using dark ink write in date again in the date box provided.
- Number box – add in number 1 and so on…
- Code box – add in the appropriate code which relates to the service user injury / mark.
  A: Pressure Ulcers
  B: Bruising
  C: Excoriation, red areas (not broken down)
  D: Cuts, wounds
  E: Scalds, burns
  F: Other (Specify)

- Provide brief details about the injury including the shape, colour, size and where the injury has occurred left or right side of body etc.
- Once the above has been completed put the appropriate number and code on the body map where the injury / mark has occurred. E.g. 1C, 2A,
- Where there is more than one injury this must be recorded in the same way using the same principle E.g. 3DBC.
- Signature must be placed in the box and the ICASS number added if known.
- Notification to CQC may be required.

3. Once the form is full put the end date on first page of Appendix 1 and start a new sheet. Each time a new sheet is started a new start date and number must be added. See bottom of the Example.

4. For those services who use the electronic care planning system, all the above steps must be completed then the document must be scanned onto the system.

5. Each record must be recorded in the diary notes, the supervisor must be notified and the PCCP amended as appropriate. If no marks or injury is found on the body and the skin is intact the body map should state this, as should the diary notes.

   Record any action the supervisor has asked to be taken in the diary notes.

6. If there is bruising, injury or marks that cannot be accounted for, these must be recorded and clearly described as above. If you are concerned as to how these marks appeared or any wounds have not received the appropriate treatment a referral to the safeguarding team must be made immediately and where appropriate CQC must be notified via the relevant notification form.

7. For all readmissions to the service and discharges from the same procedure must be followed.

8. Each time the service user is supported with personal care a check for any signs of bruising / sores / scratches / redness on the body must be made and the procedure above followed in full as required.

Support at Home / Reablement / Extra Care Housing Services only

The member of care staff must inform the supervisor immediately verbally and forward a copy of the body map to the office as soon as practically possible. The supervisor must record in the office the conversation. The rest of the procedure must be followed.