Tool Five - Buckinghamshire Safeguarding Adults Board Self-neglect Comprehensive Assessment:

SELF-NEGLECT COMPREHENSIVE ASSESSMENT – This tool can be used on its own, or with the other self-neglect tools. It is unlikely that you will complete this assessment in one visit and you may need the help of other professionals to complete certain sections.

SECTION 1 – BACKGROUND & CONTEXT			
Individual's Name		Gender	
Date of Birth		Age	
Full Address			
Name & agency of Assessor			

OTHER AGENCIES INDIVIDUAL KNOWN TO: (please tick)		
Name and Contact Details	Current	Historic

DETAILED SOCIAL & MEDICAL HISTORY: including past & present diagnosis (physical health and mental health) and details of any sensory loss. Include details of any treatment being received, coping strategies etc.

DESCRIPTION OF PRESENTING SELF-NEGLECT:

HISTORICAL PERSPECTIVE ON THE SITUATION:

INDIVIDUALS PERCEPTION OF THEIR SITUATION: including their view of whether there are problems and what they are, their desired outcomes and their willingness to accept support.

FAMILY / SOCIAL NETWORK: including whether willing/able to offer support.		
Name and Contact Details	**Yes**	**No**

FAMILY / SOCIAL NETWORK PERCEPTION OF THE SITUATION: including their view of the problems, any impact on them, desired outcomes and what support they are willing / able to provide.

SECTION 2 – HEALTH			
PHYSICAL HEALTH			
Do you currently have:	**Yes**	**No**	**Comments**
Weakness in limbs or body			
Fever			
Sweating			
Chills			
Night sweats			
Edema and/or abnormal swelling			
Heart palpitations			
Headaches			
Muscle aches			
Joint pain			
Back ache			
Hyperventilation			
Frequent urination			

SKIN			
Do you currently have:	**Yes**	**No**	**Comments**
Rashes			
Dry skin			
Long nails or breaking of nails			
Loss or recent change in texture of hair			

SLEEP			
Do you currently have:	**Yes**	**No**	**Comments**
Difficulty falling asleep			
Multiple awakenings			
Early morning awakenings			
Daytime sleepiness			
Recurring dreams / nightmares			
Consider whether referral for further clinical assessment is required			

Nutrition			
Weight if known:		**Height:**	
Do you currently have:	**Yes**	**No**	**Comments**
Appetite (including loss)			
Taste changes			
Reduced food intake / diet restrictions / fad diets			
Eating patterns (daily, weekends, away from home)			
Weight loss or gain			Amount:
			Intentional / Unintentional
Abdominal pain, indigestion, stomach cramps or belching			
Nausea or vomiting			
Change in bowel habits, constipation, diarrhea			
Issues with dentistry			
Appetite (including loss)			
Taste changes			
Consider whether referral to Dietician is required?			

MENTAL HEALTH			
Do you currently have:	**Yes**	**No**	**Comments**
Anxiety			
Low mood			
Diurnal variation of mood			
Irritability			
Agitation			
Loss of interest in things that used to give pleasure			
Pessimism			
Negative thoughts			
Suicidal ideation or self-harm			
Delusions			
Consider whether referral for further specialist assessment is required?			

ACTIVITIES OF DAILY LIVING: describe presentation and impact in relation to: washing, dressing, toileting, eating & drinking etc.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING: describe presentation and impact in relation to: ability to use phone, shopping, food preparation, house-keeping, laundry, responsibility for own medications, ability to handle finances etc.
Consider whether further referrals (for example, to Occupational Therapy) are required?

MEDICATION: Include details of all prescribed medication, including dose and frequency. Also list any non-prescription drugs, which are taken frequently.

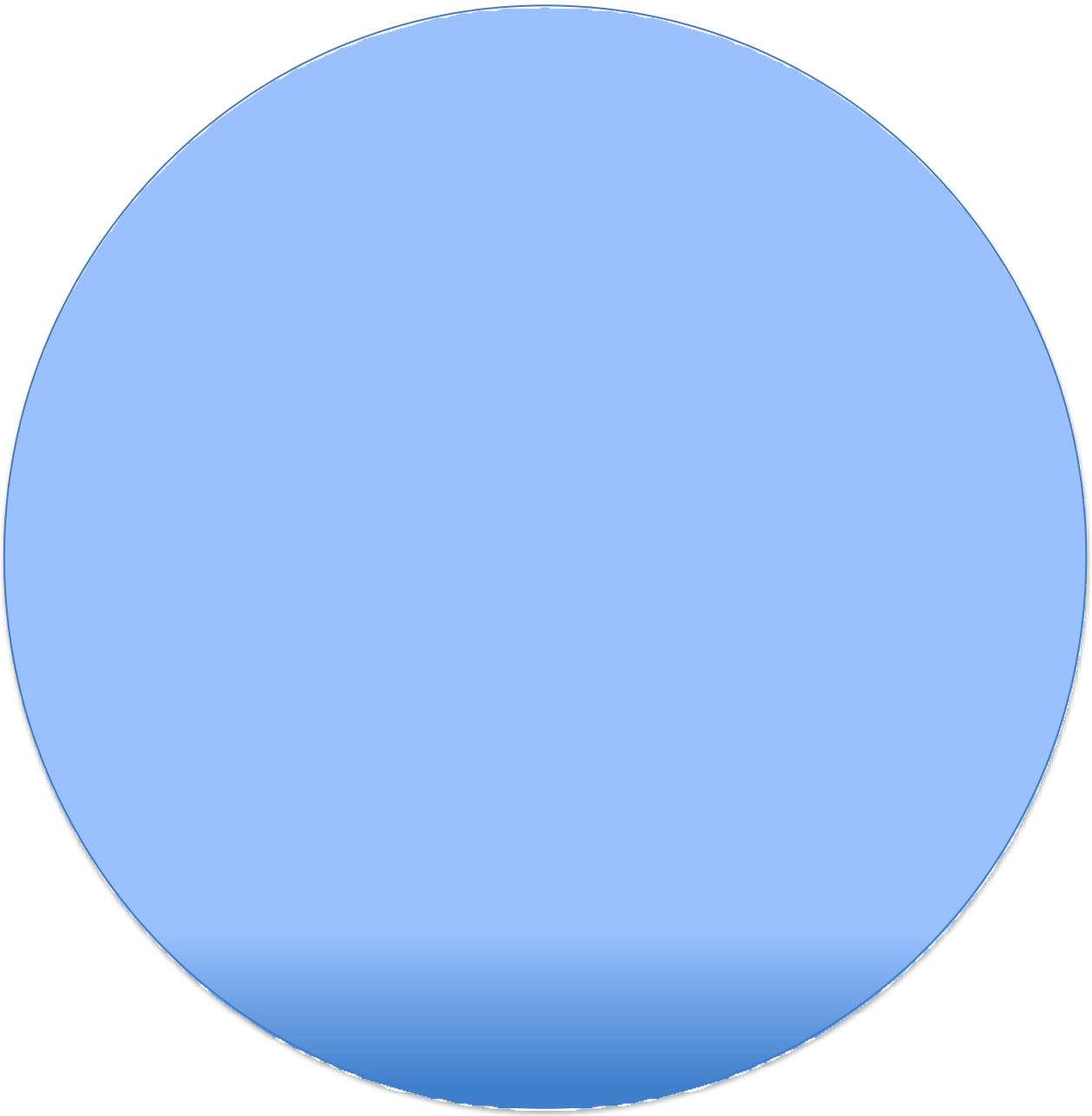
NEUROLOGY: including reference to confusion or memory loss, any differences with night vision, gait disturbance, loss of position sense, numbness and/or weakness.
Consider whether further referral is required?
If you have made reference to **confusion or memory loss**, complete the GPCOG screening tool in section 3 (if not, skip this section). For an online version of the GPCOG tool and to learn more about it, see http://gpcog.com.au . The website also contains a link to a training video, which can also be found here:

https://thebox.unsw.edu.au/video/the-gpcog-test

SECTION 3 – COGNITION			
GPCOG Screening Test			
Step 1: Patient Examination *Unless specified, each question should only be asked once*			
1.	**Name and Address for subsequent recall test** (see 6) *"I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington".* (Allow a maximum of 4 attempts).		
		Correct	**Incorrect**
2.	**Time Orientation** What is the exact date? (exact only)		
3.	**Clock Drawing** a – attached Please mark in all the numbers to indicate the hours of a clock (correct spacing required)		
4.	**Clock Drawing** b – attached Please mark in hands to show 10 minutes past eleven o'clock (1110hrs)		
5.	**Information** *Can you tell me something that happened in the news recently?* (Recently = in the last week). If a *general answer is given, e.*g. 'war', 'lot of rain', *ask for details.* Only specific answer scores.		
6.	**Recall** *What was the name and address I asked you to remember?*		
	John		
	Brown		
	42		
	West (St)		
	Aylesbury		
	Total score		
To get a total score, add the number of items answered correctly. **Total correct score out of 9**			
If patient scores 9	No significant cognitive impairment and further testing not necessary		

If patient scores 5-8	More information required. Proceed with Step 2, informant section (following page)
If patient scores 0-4	Cognitive impairment is indicated. **Refer for further investigations**

CLOCK DRAWING TEST



Informant Interview				
Date				
Informant's Name:				
Informant's relationship to patient, i.e. informant is the patient's:				
These six questions ask how the patient is compared to when s/he was well, say 5 – 10 years ago				
Compared to a few years ago:	**Yes**	**No**	**Don't Know**	**N/A**
Does the patient have more trouble remembering things that have happened recently than s/he used to?				
Does he or she have more trouble recalling conversations a few days later?				
When speaking does the patient have more difficulty in finding the right word or tend to use the wrong words more often?				
Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?				
Is the patient less able to manage his or her medication independently?				
Does the patient need more assistance with transport (either private or public)? (If the patient has difficulties due only to physical problems, e.g. bad leg, tick 'no')				
Total score				
To get a total score add the number of items answered 'no', 'don't know' or 'N/A' **Total Score out of 6:**				
If patient scores 0-3	Cognitive impairment is indicated. **Refer for further investigations**			

SECTION 4 - ENVIRONMENT	
Type of dwelling	
Freeholder	**Yes / NO**
If a tenant, provide name and address of landlord.	

ACCESS TO PROPERTY: Assess the access to all entrances and exits, including access to roof space. Refer to impact on any communal entrances and exits. Assess the garden, including size, access and condition.

SERVICES: Visual, non-expert, assessment of the condition of the plumbing, electrics, gas, and heating, including services are connected.

HOUSEHOLD FUNCTIONALITY: Assess functionality of rooms and the safety for their proposed use, e.g. can the kitchen be safely used for cooking, the bathroom for hygiene etc.,

Using the Clutter Scale Tool **P**lease score each room below; cross reference with the scale and also indicate whether access and egress to room is compromised.			
Room	**Clutter Score**	**Is access / egress compromised?**	**How high does the clutter reach?**
Bedroom 1			
Bedroom 2			
Bedroom 3			
Bedroom 4			
Hallway			
Kitchen			
Bathroom			
Cloakroom			
Lounge			
Dining room			

SANITATION: Describe the level of sanitation in the property, e.g. are the floors / work surfaces clean, is there any odour, is there rotting food, are there flies or maggots, presence of human or animal waste etc.,

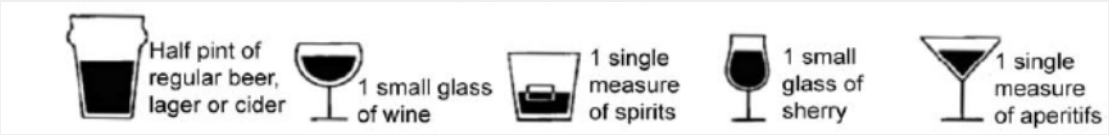
IMPACT ON OTHERS			
Risk Factor	**Yes**	**No**	**Comments**
Do any children or other adults with care and support needs live in the property?			
Are there any pets in the property?			
Are the pets well cared for or are you concerned?			
Are animals being hoarded at the property?			
Is there evidence of any infestations, e.g. bugs, mice, rats?			
Are outside areas seen by the			

resident as wildlife areas?			
Does the resident leave property inside or outside the property for wild animals?			
Consider whether referrals are required to other agencies, including the RSPCA or Environmental Health.			

SECTION 5 – SUBSTANCE USE

Alcohol use - AUDIT C

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive, in which case complete the second part of this audit.

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SCORE

Score from AUD… (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Scoring: **0–7** Lower risk **8–15** Increasing risk **16–19** Higher risk **20+** Possible dependence						
TOTAL Score: AUDIT C Score (above) + score of remaining questions Equals						
Total score >18 consider referral to a treatment service **Total score >24** consider direct referral for structured treatment (**>30 BE AWARE** possible dependent drinking)						

TOTAL SCORE

	Yes	No
Do you, or have you used non-prescribed and/or illegal drugs?		
If you have answered **YES**, please tell us what you have used, quantities and when last used.		
If you have answered **YES**, please tell us when you had treatment and who provided this treatment.		
If you have answered **YES**, please state what you feel would be helpful and effective support.		

What next? – Once you have completed this tool you can use it alongside other assessments including Care Programme Approach, Section 9 Assessments etc. It can also be used as part of your referral to RAMP or other multi-agency forums.