Master Care Ltd

WARNING: Your System details are incomplete and so the content of this policy may not be customised to your organisation.

Review Sheet

Last Reviewed	Last Amended	Next Planned Review
21 Nov '22	21 Nov '22	in 12 months, or sooner as required.

Business impact	 **MEDIUM IMPACT** Changes are important, but urgent implementation is not required, incorporate into your existing workflow.
Reason for this review	Scheduled review
Were changes made?	Yes
Summary:	This policy will support staff with pressure ulcer management. It has been reviewed with minor amendments made to sections 4.5, 5.1, 5.3 and key facts only. References have also been reviewed to ensure they remain current.
Relevant legislation:	• The Care Act 2014 • Care Quality Commission (Registration) Regulations 2009 • The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Medicines Act 1968 • Mental Capacity Act 2005 • Mental Capacity Act Code of Practice
Underpinning knowledge - What have we used to ensure that the policy is current:	• Author: Lister S, Hofland J & Grafton H, (2020), *Royal Marsden Manual of Clinical Nursing Procedures*. [Online] Available from: [Accessed:] • Author: Judy Waterlow, (2005), *Waterlow Score Card*. [Online] Available from: http://www.judy-waterlow.co.uk/the-waterlow-score-card.htm [Accessed: 21/11/2022] • Author: NHS Improvement, (2018), *Pressure ulcers: revised definition and measurement*. [Online] Available from: https://www.england.nhs.uk/pressure-ulcers-revised-definition-and-measurement-framework/ [Accessed: 21/11/2022] • Author: National Institute for Health and Social Care Excellence, (2014), *Pressure ulcers: prevention and management - Clinical guideline [CG179]*. [Online] Available from: https://www.nice.org.uk/Guidance/CG179 [Accessed: 21/11/2022] • Author: National Institute for Health and Care Excellence, (2015), *Pressure ulcers: Quality standard [QS89]*. [Online] Available from: https://www.nice.org.uk/guidance/qs89 [Accessed: 21/11/2022] • Author: European Pressure Ulcer Advisory Panel, (2014), *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide*. [Online] Available from: http://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf [Accessed: 21/11/2022]
Suggested action:	• Encourage sharing the policy through the use of the QCS App
Equality Impact Assessment:	QCS have undertaken an equality analysis during the review of this policy. This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

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1. Purpose

1.1 To ensure that all Service Users who are at risk of pressure ulcer development, or who have pressure ulcers, are appropriately assessed, have an individualised plan of care implemented and appropriate timely reviews.

1.2 To support Master Care Ltd in meeting the following Key Lines of Enquiry:

Key Question	Key Lines of Enquiry
EFFECTIVE	E1: Are people's needs and choices assessed and care, treatment and support delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?
RESPONSIVE	R1: How do people receive personalised care that is responsive to their needs?
SAFE	S1: How do systems, processes and practices keep people safe and safeguarded from abuse?
WELL-LED	W4: How does the service continuously learn, improve, innovate and ensure sustainability?

1.3 To meet the legal requirements of the regulated activities that {Master Care Ltd} is registered to provide:

- The Care Act 2014
- Care Quality Commission (Registration) Regulations 2009
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Medicines Act 1968
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice

2. Scope

2.1 The following roles may be affected by this policy:

- Registered Manager
- Care staff

2.2 The following Service Users may be affected by this policy:

- Service Users

2.3 The following stakeholders may be affected by this policy:

- Family
- Commissioners
- External health professionals
- Local Authority
- NHS

3. Objectives

3.1 To establish evidenced-based best practice and a standardised approach in the prevention and treatment of pressure ulcers, whilst reducing the incidence and severity of pressure ulcers within Master Care Ltd.

4. Policy

4.1 Master Care Ltd is committed to providing consistent, evidence-based quality care in the prevention, management and treatment of pressure ulcers for all Service Users. This will incorporate a holistic assessment and demonstrate Service User/carer involvement in the care provided.
4.2 An assessment will be undertaken for all Service Users prior to the start of any care provision in relation to the condition of their skin and the risk of pressure ulcers. The risk level will be documented in the Care Plan. Service Users who are identified as being at risk of developing pressure ulcers will have a detailed plan of Care established. This will directly reflect NICE guidance for pressure ulcer prevention and management (2014).
4.3 Service Users identified as at risk will be informed and advised regarding prevention measures and strategies. Master Care Ltd will, without delay, refer the Service User to the GP or Community Nursing Team for urgent assessment.
4.4 In the absence of a Service User's capacity to be involved, the Care Worker will make decisions in the Service User's best interest in accordance with the Mental Capacity Act (2005).
4.5 Where a pressure ulcer is identified, either on transfer from another care provider or at any time during the provision of care and support to the Service User, any concerns about skin integrity or the development of a pressure ulcer will be reported in line with local safeguarding procedures and a notification sent to the Care Quality Commission in line with statutory reporting requirements. Additionally, Master Care Ltd will ensure that an urgent referral is made to the GP or Community Nursing Team.
All pressure ulcer occurrences will be investigated, and lessons learned applied to ensure continuous quality improvement.
4.6 In order for this policy to be effective, the following is expected:

- This policy and other best practice resources will be available to and for Care Workers on induction to Master Care Ltd. This is in addition to ongoing training and support to maintain knowledge, skills and competence in relation to managing skin care
- There will be suitable, sufficient and well-maintained equipment available at Master Care Ltd to meet and support the assessed needs of the Service User
- The reporting of incidences will be in accordance with the policy of Master Care Ltd that includes necessary reporting to the Regulator when required

5. Procedure

5.1 Contributory Factors

Pressure and shearing are significant causes of pressure ulcers but there are factors that directly contribute to an individual's overall risk of developing a pressure ulcer. A Care Worker supporting Service Users will be aware of these factors and how to implement strategies to try to minimise the risk. These include:

- Decreased/impaired level of mobility
- Sensory impairment
- Incontinence
- Level of consciousness
- Acute, chronic and terminal illness comorbidity
- Posture
- Cognition, psychological status
- Previous pressure damage
- Extremes of age
- Nutrition and hydration status
- Significant weight loss
- Moisture to the skin
- Creased bed sheets
- Tight clothing
- Incorrectly used or inappropriate type of pressure relieving device

5.2 Pressure Ulcer Risk Assessment

- All Service Users will be assessed for the risk of developing a pressure ulcer by suitably trained staff at Master Care Ltd, using a recognised risk assessment tool prior to Care commencing
- Formal assessment will guide Care Workers to identify those at highest risk of developing pressure damage. The Care Worker must be aware that it is the individual factors that raise the risk, not the overall score and, therefore, will introduce personalised strategies focusing on the identified risk factors and clinical judgement
- Outcomes of risk assessments and agreed strategies will be documented in the Service User's Care Plan and will be communicated to other Care Workers to ensure that care is provided in accordance with assessed need
- The Service User's skin condition will be assessed on every care intervention (e.g. personal hygiene, repositioning, toileting) and concerns identified will be immediately communicated to the Registered Manager. The Care Worker must be able to identify, report and record the following skin conditions:
  - Persistent erythema (redness)
  - Non-blanching erythema
  - Blisters
  - Localised heat
  - Localised oedema (fluid)
  - Localised indurations (hardening of the area)
  - Purplish/bluish localised areas
  - Localised coolness if tissue death occurs

5.3 Pressure Ulcer Prevention

- Pressure ulcer prevention Care Plans will be in place for Service Users. These will detail specific risk management strategies including repositioning regimes and the use of therapeutic equipment. Where able, Service Users will be involved in the production of the Care Plan and will receive advice and guidance on the benefits and frequency of repositioning

- Service Users who are incontinent will have their skin assessed regularly and there will be a timely response to meeting need. Soap and water will be avoided when cleaning Service Users who are incontinent as this can promote the development of pressure ulcers. Mild pH balanced cleansers will be used as an alternative. Prescribed skin cleansers, barriers or emollients must be administered as directed by the prescriber and recorded as such on the topical medication record
- Service Users who can remain active or change their position will be encouraged to do so. Support and assistance must be provided to those who cannot easily change their position. A Reposition Chart and guidance are available in the Forms section of this policy
- For Service Users who require the use of clinical devices such as nasogastric tubes, catheters, PEGs, etc., care must be taken to ensure that the skin is monitored to prevent medical device related pressure ulcers
- Care Workers must work as trained, using correct positioning, correct moving and handling techniques and correct equipment to minimise the risk of shearing

5.4 Categorisation

- Pressure ulcers will be categorised according to the European Pressure Ulcer Advisory Panel (EPUAP 2014) Pressure Ulcer Category Tool
- If a Care Worker is in any doubt about the correct categorisation of a wound, a second opinion will be sought from a registered nurse e.g. the district nurse
- With regard to record keeping, pressure ulcers will not be reverse categorised. A Category 4 pressure ulcer does not become a Category 3 as it heals. As the ulcer heals it will be described as a healing Category 4 pressure ulcer
- Body maps and photographs (with the Service User's consent) of any pressure damage must be documented and a specific wound Care Plan implemented. Master Care Ltd will be aware of its Data Protection responsibilities where photographs are taken
- Master Care Ltd will refer to the Royal Marsden Manual of Clinical Nursing Procedures for current recommended practice

5.5 Therapeutic Equipment

Pressure reducing surfaces or devices are used to reduce and redistribute the overall pressure to the vulnerable bony prominences, such as the sacrum (bottom of the spine), hips, buttocks and heels (NICE 2014).

- Following an assessment by the district nursing team or tissue viability specialists, Service Users at high risk of developing pressure ulcers may be assessed as requiring a pressure redistribution mattress. The type of device that a Service User needs will depend on their circumstances, mainly:
  - Mobility
  - Skin assessment outcome
  - Level of risk
  - Site that is at risk
  - Service User's weight
  - General health
- Pressure redistribution devices will be introduced as soon as possible when required, and the Care Worker must be aware of how to refer to other members of the multidisciplinary team to obtain equipment in a timely manner
- The setting and correct functioning of the pressure mattress must be checked and recorded on a daily basis
- Pressure relieving mattresses must be properly cleaned and maintained in line with the cleaning schedules at Master Care Ltd and manufacturers' guidance
- Air mattresses will be annually PAT (Portable Appliance Testing) tested and the Care Workers will have access to the manufacturer’s guidance regarding settings and alarm support
- Cushions – appropriate pressure-relieving cushions may be provided for Service Users at high risk of, or with existing pressure ulcers, who are able to sit out of bed

- This policy **does not** support the use of the following as pressure reducing aids or devices:
  - Synthetic or genuine sheepskins
  - Water filled gloves
  - Donut ring type seat cushions
- Portable pressure relieving devices such as heel lift boots and silicone gel pads are single use only and will only be used for those Service Users intended. Portable devices will be subject to proper cleaning and maintenance

5.6 Record Keeping

In addition to maintaining a Care Plan and pressure prevention risk assessment, the following apply:

- Ensure that relevant documentation is updated and reflective of any changes in a Service User's condition
- For Service Users nursed in bed, repositioning charts will be used
- Charts must clearly state the frequency of repositioning to be undertaken and clearly document when this was undertaken. Please refer to the Forms section of this policy for the Reposition Chart and guidance information
- Fluid and nutrition charts, when used, must be completed accurately so that the level of risk can be accurately judged. If the Service User refused food or drink when offered, this will also be recorded

5.7 Reporting

- Cases of single category 1 and 2 pressure ulcers must be considered as requiring early intervention to prevent further damage. If there are concerns regarding poor practice, it will be escalated and recorded as a clinical incident in line with local safeguarding procedures and a statutory notification will be made to the CQC
- Where there is a combination of moisture associated skin damage and pressure ulcers, this will be reported in accordance with the Category of the pressure ulcer
- Pressure damage at Category 3 and 4 (to include unstageable and suspected deep tissue injury), will be reported to the local safeguarding teams and the Regulator. This will be for all pressure ulcers including those that may develop in other settings
- To support learning and reflection, Master Care Ltd will complete a root cause analysis investigation for any home-acquired pressure damage Category 3 or 4
- For Service Users who present with a Category 3 or 4 ulcer, or deteriorating pressure ulcer, an urgent referral to a specialist support professional (e.g. tissue viability nurse) will be made for advice and guidance
- All incidents of pressure ulcers and moisture associated skin damage will be recorded internally, monitored, investigated and reflected on to improve care practice. Staff will be made aware of the findings in line with the audit procedures at Master Care Ltd
- Where a Service User transfers from another care setting (e.g. hospital or respite) or from another care provider and develops any Category 3 or 4 pressure ulcer on admission, it must be escalated and reported to the previous care provider as a clinical incident and Master Care Ltd must follow its own safeguarding and regulatory reporting procedures

6. Definitions

6.1 European Pressure Ulcer Advisory Panel (EPUAP)

- "An organisation of experts whose aim is to provide relief for persons suffering from, or at risk of, pressure ulcers, through research and the education of the public and by influencing pressure ulcer policy in all European countries towards an adequate patient-centred and cost-effective pressure ulcer care."

6.2 Medical Device Related Pressure Ulcer

- Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes. NPUAP (2015)

6.3 Oedema

- A condition characterised by an excess of watery fluid collecting in the cavities or tissues of the body

6.4 Erythema

- Superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries

6.5 Shearing

- Is the force which frequently accompanies both friction and direct pressure. Shear forces develop in the tissues that are distorted and pulled so that the blood supply is disrupted

6.6 Comorbidity

- This is the presence of two or more diseases or conditions in an individual at the same time

6.7 Pressure

- This is continuous physical force exerted on or against an object by something in contact with it

6.8 Pressure Ulcer

- A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful

Key Facts - Professionals

Professionals providing this service should be aware of the following:

- Encouraging good skin care, movement and regular repositioning will help reduce and eliminate pressure damage
- Pressure prevention involves a holistic approach to care and individually tailored care planning involving Service Users
- Care Workers are responsible for keeping up to date with national recommendations around practice in pressure prevention, will ensure that staff have up to date training

Key Facts - People affected by the service

People affected by this service should be aware of the following:

- Where necessary, you will be referred to other agencies, with your consent, to request the supply of equipment to help reduce the risk of developing pressure ulcers and we will support you to access specialist healthcare professionals for further advice and support
- You can expect to be supported by staff who are knowledgeable, competent and skilled with skin care management
- You will feel supported to maintain your independence with looking after your skin. This will include regular repositioning, physical activity and skin care monitoring and management

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Further Reading

As well as the information in the 'underpinning knowledge' section of the review sheet we recommend that you add to your understanding in this policy area by considering the following materials:

EPUAP - Stop Pressure Ulcers:
https://www.epuap.org/stop-pressure-ulcers/#:~:text=Every%20year%2C%20the%20EPUAP%20holds,the%20professionals%20and%20our%20politicians
Independent Nurse - Article on 'Prevention of Pressure Ulcers in Community Care Settings':
http://www.independentnurse.co.uk/clinical-article/prevention-of-pressure-ulcers-in-community-care-settings/176273/
Skills for Care - Leaflet - Pressure ulcers - The warning signs and how to prevent them:
https://www.skillsforcare.org.uk/Documents/Topics/Safeguarding/Pressure-ulcers-leaflet-for-front-line-care-workers.pdf

Outstanding Practice

To be ' outstanding ' in this policy area you could provide evidence that:

- The wide understanding of the policy is enabled by proactive use of the QCS App
- Master Care Ltd has identified a link role to join relevant associations, attend training and support Care Workers with best practice
- Master Care Ltd has become involved in national and local initiatives such as 'Stop the pressure' campaigns in order to raise awareness and knowledge of pressure damage and how to manage it
- The reporting of incidences and prevalence of pressure ulcers as well as focused audits within Master Care Ltd in order to identify themes and benchmark practice take place

Forms

The following forms are included as part of this policy:

Title of form	When would the form be used?	Created by
Adapted Waterlow Score Risk Assessment Form - CC96	To assess the risk of developing a pressure sore	QCS
Reposition Chart - CC96	To record a Service User's position changes	QCS
Reposition Chart Guidance Notes and Example - CC96	As guidance when completing a reposition chart	QCS

Name of Service User:	
DOB:	
ID:	

More than one score/category can be used. The tool identifies three 'at risk' categories,

1. A score of 10-14 indicates 'at risk'
2. A score of 15-19 indicates 'high risk', and
3. A score of 20 and above indicates 'very high risk'

Undertake and document a risk assessment prior to the service commencing or on the first home visit. Reassess if there is a change in the individual's condition and repeat regularly according to local procedures. **Consider the scores in bold and record in the box next to the number, e.g. if the Service User is male score 1, etc. Add the total score to give a risk category.**

Sex		
Male	**1**	
Female	**2**	

Age		
14 – 49	**1**	
50 – 64	**2**	
65 – 74	**3**	
75 – 80	**4**	
81+	**5**	

Build/Weight for Height (BMI=weight in Kg/height in m^2)		
Average – BMI 20-24.9	**0**	
Above average – BMI 25-29.9	**1**	
Obese – BMI > 30	**2**	
Below average – BMI < 20	**3**	

Continence		
Complete/catheterised	**0**	
Incontinent urine	**1**	
Incontinent faeces	**2**	
Doubly incontinent (urine & faeces)	**3**	

Skin Type – Visual Risks Area		
Healthy	**0**	
Tissue paper (thin/fragile)	**1**	
Dry (appears flaky)	**1**	
Oedematous (puffy)	**1**	
Clammy (moist to touch)/pyrexia	**1**	
Discoloured (bruising/mottled)	**2**	
Broken (established ulcer)	**3**	

Mobility		
Fully mobile	**0**	
Restless/fidgety	**1**	
Apathetic (sedated/depressed/reluctant to move)	**2**	
Restricted (restricted by severe pain or disease)	**3**	
Bedbound (unconscious/unable to change position/traction)	**4**	
Chair-bound (unable to leave chair without assistance)	**5**	

Nutritional Element		
Unplanned weight loss in past 3-6 months	**2**	
< 5% **Score 0**, 5-10% **Score 1**, >10% **Score 2**	**0-2**	
BMI >20 **Score 0**, BMI 18.5-20 **Score** 1, BMI < 18.5 **Score 2**	**0-2**	
Service User acutely ill or no nutritional intake > 5 days	**2**	

Special Risks – Tissue Malnutrition		
Multiple organ failure/terminal cachexia	**8**	
Single organ failure e.g. cardiac, renal, respiratory	**5**	
Peripheral vascular disease	**2**	
Anaemia = Hb < 8	**2**	
Smoking	**1**	

Special Risks – Neurological Deficit		
Diabetes/ MS/ CVA/ motor/ sensory/ paraplegia Max 6	**4-6**	

Special Risks – Surgery/Trauma		
On table > 6 hours	**8**	
Orthopaedic/ below waist/spinal (up to 48 hours post op)	**5**	
On table > 2 hours (up to 48 hours post op)	**5**	

Special Risks – Medication		
Cytotoxic, anti-inflammatory, long term/high dose steroid Max 4	**4**	

TOTAL SCORE:	
Date:	
Time:	
Name of Assessor:	

Ensure that a plan of care is implemented/reviewed for all identified areas of concern.

What action is now required?

Service User Name:			
Agreed reposition schedule (indicate as appropriate): **Equipment to be used:** **Number of staff:**	**HOURLY** **2 HOURLY** **4 HOURLY** **6** **HOURLY** **Other:**		
Date:	**Where applicable, add the required setting of the pump:**		
Time	**Position** [i.e. Left (L), Right (R), Back (B), Front (F), Mobilised (M), Up (U), Other (O)]	**Observations**	**Signature**
01:			
02:			
03:			
04:			
05:			
06:			
07:			
08:			
09:			
10:			
11:			
12:			
13:			
14:			
15:			
16:			
17:			
18:			

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Time	Position [i.e. Left (L), Right (R), Back (B), Front (F), Mobilised (M), Up (U), Other (O)]	Observations	Signature
19:			
20:			
21:			
22:			
23:			
00:			

Staff must document if repositioning has been offered but declined by the Service User. Where repositioning is frequently declined, the Care Plan must be updated to reflect this, with strategies for the management of this included. Where Service Users require the use of an air mattress, staff are responsible for ensuring that the pump is set in accordance with the Service User's current weight. As weight changes, the pump setting should be reviewed to ensure that it remains accurate. Staff should check the setting of the air mattress at every reposition opportunity and record (as per the example below). Some air mattresses have automatic settings, in which case staff should state 'automatic' in the top section of this form.

Service User Name:	Joe Bloggs		
Agreed reposition schedule (indicate as appropriate):	**HOURLY 2 HOURLY 4 HOURLY 6 HOURLY Other:**		
Equipment to be used:	**Apollo 8 Airflow Mattress - setting number 4**		
Number of staff:	**2**		
Date: 1/3/21	**Where applicable, add the required setting of the pump:** Setting 4		
Time	**Position** [i.e. Left (L), Right (R), Back (B), Front (F), Mobilised (M), Up (U), Other (O)]	**Observations**	**Signature**
01:			
02:45	L	Setting 4 - skin inspection, skin intact	LC
03:			
04:			
05:			
06:50	B	Setting 4 – skin inspection, skin intact	RC
07:			
08:			
09:			
10:			
11:02	R – declined (so 30 degree tilt offered and accepted to right side)	Setting 4 – skin inspection, skin intact	PR
12:			
13:			
14:			
15:00	L	Setting 4 – skin inspection – slight redness to right heel – elevated off the base of the mattress	PR

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Time	Position [i.e. Left (L), Right (R), Back (B), Front (F), Mobilised (M), Up (U), Other (O)]	Observations	Signature
16:			
17:			
18:53	R	Setting 4 – skin inspection – redness remains to right heel, cream applied and elevated from bed	PC
19:			
20:			
21:			
22:			
23:00	Left side	Setting 4 – skin inspection – no red area to right heel, skin intact	LC
00:			