care inspectorate

Care Trigger Tool – Care Homes for Older People – Wound Assessment and Management

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Care Trigger	Checklist	Best Practice Guidance	Outcome if the service cannot provide the evidence to support they have this in place
Does the care service have policies in place for: • Wound Assessment and Management. Which addresses wound pain (assessment and management).	Staff working in the care service are familiar with this policy /procedure. The policy guides staff to best practice and inform the care for residents.	HIS formerly NHS QIS (2009) Best Practice Statement: Prevention and Management of Pressure Ulcers. RCN / NICE guideline (2005) Pressure ulcers: The management of pressure ulcers in primary and secondary care. Best Practice Statement on Minimising Trauma and Pain in	Requirement issued that this policy is devised or updated which address wound assessment management and wound pain. These policies are based on current best practice and are implemented within a 13 week timescale. Inspectors can liaise with Professional Adviser Tissue Viability (PATV) for advice / support.

		Wound Management (2007).	
Does the care service have a wound assessment process in place? Do residents who have pressure ulcers / wounds have an initial wound assessment carried out?	There is a visible record of initial wound assessment. Information is recorded on appropriate documentation eg • body map • initial wound assessment chart • ongoing assessment chart • pressure ulcer grading tool in use.	HIS formerly NHS QIS BPS (2009) Pressure Ulcer Prevention and Management of Pressure Ulcers. NHS QIS (2009) Scottish adapted EPUAP grading tool. www.tvonline.com Scottish Wound Assessment and Action Guide (SWAAG). Scottish adapted EPUAP grading tool.	Requirement that assessment process and appropriate tools / documentation are put in place immediately to enable wounds to be assessed appropriately. Staff training in this process and application of the tool / documentation will be necessary. Timescale: Immediately. Inspectors can liaise with PATV for advice / support.
All residents with wounds have a care plan in place which outlines their individual wound care needs.	The wound management care plan is in place which outlines: Method of cleansing Specific prescribed Topical skin	HIS formerly NHS QIS (2009) Scottish adapted EPUAP grading tool. Scottish Wound Assessment and Action Guide (SWAAG). www.tvonline.com	Requirement issued that each resident with a pressure ulcer or wound has a clear plan of care to meet their individualised wound care needs. Timescale: Immediately.

	applications Dressings Bandages Frequency of dressing changes Frequency of re-assessment in relation to wound / pain. Separate assessments and care plans for each pressure ulcer / wound is good practice. Changes in wound assessments / treatment are updated in the care plan with clear rationale for the changes.	Best practice statement on minimising pain and trauma in wound care (2007).	Inspector to liaise with PATV for advice / support.
Does the care service keep a record of administration of wound dressings / treatments?	A record of administration of prescribed dressings products / topical applications is evidenced from the MAR charts wound assessment	Scottish Wound Assessment and Action Guide (SWAAG). www.tvonline.com HIS formerly NHS QIS (2009) Best Practice Statement: Prevention and Management of Pressure Ulcers.	Requirement that the service must implement a method to ensure that a record is kept of all prescribed dressings used for each resident. Timescale: Immediately. Inspector can liaise with PATV for advice / support.

	charts / wound care plan or wound treatment plan and evaluation of care chart.		
The care service requires to demonstrate how they manage wound infection.	Does the care service keep a documented record of: • wound swab investigations, results and treatment initiated (dressings and antibiotics). ▪ the progress of the wound infection is documented (Short term care plan). ▪ PPE required for the duration of wound infection. Method of disposal of infected materials	HIS formerly NHS QIS (2009) Best Practice Statement: Prevention and Management of Pressure Ulcers. Infection Control in Adult Care Homes: Final Standards (2005). Management of Care Equipment Policy and Procedure (2009) Health Protection Scotland.	Requirement is issued that the service require to keep a record of: • Wound swabs / investigations • Management / treatment of wound infection • Infection prevention and control precautions being taken during this time. Timescale: Immediately. Inspector can liaise with TVA for advice / support.

References:

- Best Practice Statement: Pressure Ulcer Prevention and Management of Pressure Ulcers (2009) Healthcare Improvement Scotland formerly NHS QIS
- Best Practice Statement on Minimising Trauma and Pain in Wound Management (2007) Wounds UK / Mölnlycke Health Care
- Infection Control in Adult Care Homes: Final Standards (2005) Scottish Executive
- Management of Care Equipment Policy and Procedure (2009) Health Protection Scotland
- Scottish adapted EPUAP grading tool (2009) Healthcare Improvement Scotland / National Assoc of Tissue Viability Nurse Specialists (Scotland) www.tvonline.com
- Scottish Wound Assessment and Action Guide (SWAGG) (2010) Healthcare Improvement Scotland. www.tvonline.com

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NOTE
This information is produced for the guidance of Care Inspectorate staff, in the first instance. The contents will be of interest to others with an interest in wound assessment and management. The contents should not be regarded as a statement of Care Inspectorate policy, nor relied upon as a comprehensive statement of best practice, but as common sense guidance on issues of topical interest based upon authoritative statements of best practice in the relevant field, at the time of preparation, and which may be of assistance to Care Inspectorate staff when reviewing care homes practices and policies