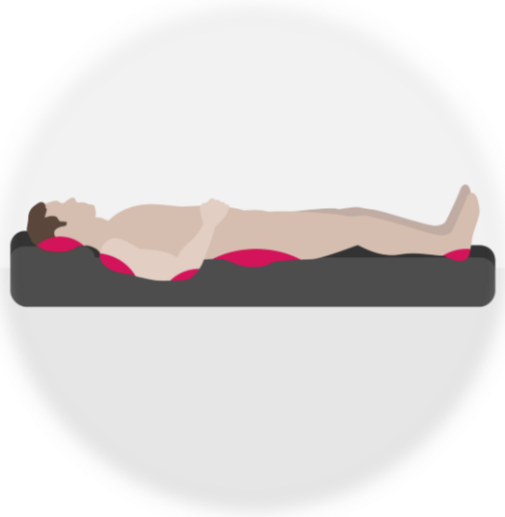

Examples of Good Practice in Pressure Ulcer Prevention in Norfolk Care Homes

Final Report of the Pressure Ulcer Project Group

Please contact Healthwatch Norfolk if you require an **easy read**; **large print** or a **translated** copy of this report.

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January 2017

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Who we are and what we do

Healthwatch Norfolk is the local consumer champion for health and social care in the county. Formed in April 2013, as a result of the Health and Social Care Act, we are an independent organisation, with statutory powers. The people who make decisions about health and social care in Norfolk have to listen to you through us.

We have five main objectives:

1. Gather your views and experiences (good and bad)
2. Pay particular attention to underrepresented groups
3. Show how we contribute to making services better
4. Contribute to better signposting of services
5. Work with national organisations to help create better services

We are here to help you influence the way that health and social care services are planned and delivered in Norfolk.

Acknowledgements

In conducting this project, we would like to thank the following people for their support:

- All of the care homes we have contacted and in particular those who contributed their time in meeting with us and sharing their practice on pressure ulcer prevention and care
- Richard Pendlebury, Integrated Community Equipment Service Business Manager, Norfolk County Council
- Mick Sanders, Head of Integrated Commissioning, Norwich Clinical Commissioning Group
- Faye Gower-Smith, Integrated Community Equipment Service & Norfolk County Council

Summary

In 2014 Healthwatch Norfolk received some comments from the public about the late delivery of equipment from the community equipment service. Coupled with this, a rise in the number of avoidable pressure ulcers deemed to be 'serious incidents' came to our attention along with the suggestion that the late delivery of specialist equipment could be a contributing factor. In response, a project to explore the community equipment service and pressure ulcers was initiated.

The project started in August 2015, commencing with the engagement of lead commissioners of Norfolk's community equipment service and key players in community services. This led to a site visit to the local depot of the community equipment service provider to gain a better understanding of service provision and in particular, pressure-relieving equipment. We learnt that the service is called the 'Integrated Community Equipment Service' (or ICES) and the current provider is NRS Healthcare. Joint-commissioning arrangements exist between Norfolk County Council and our five local Clinical Commissioning Groups

Detailed information was researched and sourced to better inform the direction of the investigation, including non-commercially sensitive data on the types of pressure relieving equipment provided and it's end user. This led to the prioritisation of care homes and their residents – adults and older people - as the predominant receivers and users of pressure relieving equipment. To first understand the principles of good practice in prevention i.e. what is most effective, a literature review was performed. This led us to focus on; training of staff, assessment of pressure ulcer risk, care planning including the effective use of appropriate equipment, monitoring and reviewing care and repositioning.

Looking for good practice felt like the right starting point and we were also keen to engage with care homes in a positive way to encourage them to participate in our information gathering. To this end, we chose to use semi-structured interviews with a series of questions grounded in the findings from the literature review. A list of care homes currently providing care funded by NHS or local adult social care service was compiled. After sending an introductory letter we telephoned care homes and arranged a meeting with the care home manager or another senior member of staff.

Between April and September 2016, we visited 45 care homes, meeting with care staff. The responses to our questions about care and the examples of good practice proposed by the staff were recorded and collated. Notes of the meetings were entered onto SurveyMonkey and a contents analysis used to reveal recurring themes and conduct a simple count of responses.

Our findings reveal a significant variation in practice between the homes we visited. Seventy per cent of our sample included specific training on

pressure ulcer prevention and care in their induction training for new staff and around half included it in both induction and on-going, mandatory training programmes. East Coast Community Healthcare offered free training to care homes in East Norfolk and the uptake was good. We were told staff assess the skin integrity of their residents when providing personal care such as help with bathing or dressing and are commonly using assessment tools such as the Waterlow risk tool and body maps. Other preventive factors such as good nutrition and hydration, continence care, hygiene and skin care were also described to us. Care staff were able to describe in detail the repositioning of residents at risk of pressure ulcers and the majority of homes were using turn (repositioning) charts for recording purposes. Pressure Ulcer Champions were a feature in 20% of homes visited.

When a change in the resident's skin is identified, the route for reporting differs, although many homes contact community services for support, the response they receive can differ. If a resident requires pressure-relieving equipment, community nurses usually decide what is needed and will order it. The majority of care homes report being very satisfied with the prompt delivery of equipment and the quality of instructions provided by delivery drivers. For some care homes, collection of equipment takes longer than desired.

As the project progressed, it was revealed that pressure ulcer care planning is complex. There may be two care plans in operation; one held electronically by community nurses in addition to the resident's own care plan maintained by the care home staff. Some care home staff told us that they experience difficulties with the triage process via the 'Single Point of Access' and that community nurses do not consistently inform them of the treatment and care given whilst visiting a resident.

Staff highlighted concerns over the number of residents discharged from hospital with a pressure ulcer and thought the proportion was worryingly high. Residents are entering care homes with increasingly complex health needs and frailty; those admitted when close to end of life, with palliative care needs, present specific challenges.

Care home staff were pleased to share those practices they were most proud of and a list of good practice in pressure ulcer prevention and care has been compiled which can be shared with all care homes in Norfolk. In the eastern locality, uptake of training offered by the community nursing provider is good; this could be replicated across the county to improve equity of access. An improvement in communication between community nursing services and care home staff is needed, to better enable good care of residents with pressure ulcers.

1. Why we looked at this

1.1 Local evidence

Healthwatch Norfolk routinely monitors a wide range of information reported by our local Clinical Commissioning Groups, including information on patient safety and the quality of local services. In late 2014, Healthwatch Norfolk became aware of an increase in the reported number of **pressure ulcers** in Norfolk patients. At the same time, we received some comments from the public on delayed delivery of **equipment used to prevent or treat pressure ulcers**. We chose to bring these concerns together as a priority for investigation in our strategy for 2015-2017.

An equipment service is one that supplies equipment and encompasses; service user assessment, procurement and storage of items of equipment, issue (delivery) to service users, fitting of some types of equipment in users' homes and the associated cleaning, refurbishment, maintenance and testing of equipment. This project is about the Integrated Community Equipment Service in Norfolk, which is jointly commissioned by Norfolk County Council and the county's five Clinical Commissioning Groups (CCGs). Healthwatch Norfolk took a special interest in the link between equipment and pressure ulcers. This project has a specific focus on pressure-relieving equipment that is supplied to prevent, or treat, pressure ulcers.

1.2 Pressure ulcers

Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure and are sometimes known as "bedsores" or "pressure sores". Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle (see *Figure 1*).

Pressure ulcers can develop when a large amount of pressure is applied to an area of skin over a short period of time. They can also occur when less pressure is applied over a longer period of time. The extra pressure disrupts the flow of blood through the skin. Without this blood supply, the affected skin becomes starved of oxygen and nutrients and begins to break down, leading to an ulcer forming. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time (see *Figure 2 overleaf*).

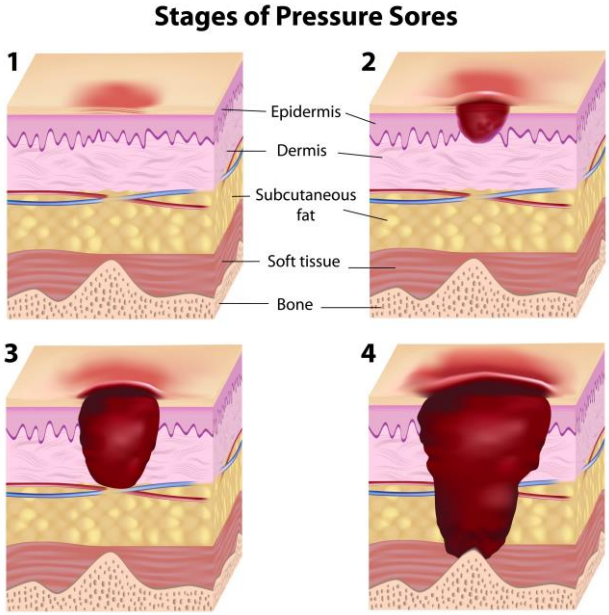


Figure 1. Stages of Pressure Sores

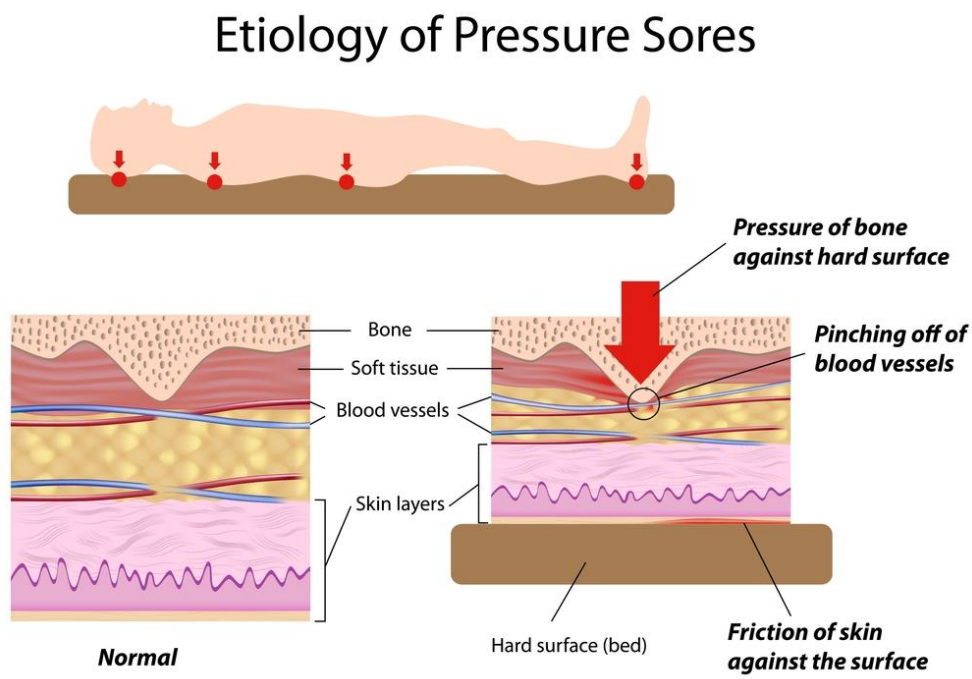


Figure 2. Pressure points

1.3 Monitoring and reporting pressure ulcers in Norfolk patients

Pressure ulcers must be monitored and reported as 'serious incidents' as a matter of patient safety and the quality of service provision. This means that staff and managers in Norfolk's provider organisations are required to identify and report the number and 'grade' (severity) of pressure ulcers in people currently receiving their care. Reports of pressure ulcers are submitted to local CCGs and managers at the North East London Commissioning Support Unit (NEL CSU) on a monthly basis and also to the regional team at NHS England Midlands & East. The requirement is to report Grade 3 and Grade 4 pressure ulcers, however Grades 1 and 2 may also be reported, as well as those pressure ulcers deemed to be 'avoidable'. The criteria for an 'avoidable' pressure ulcer was not clear to us and appeared to be subjective and yet clearly influenced the statistics.

1.4 What's being done about pressure ulcers?

We conducted desk-based research on the pressure ulcers strategies of CCG Governing Bodies in Norfolk and reviewed the *Strategic Quality Alliance's Pressure Ulcer Workshop* and a *Pressure Ulcer Reporting Briefing Paper* written by the NEL CSU for our local CCGs. Together, these reports indicated that:

- patients, service users, family carers and the public can find information on pressure ulcers in the minutes of meetings held by CCG Governing Bodies - and also see what they are doing to address the problem
- whilst CCGs report on the numbers of 'hospital acquired pressure ulcers' at Grades 3 and 4 pressure ulcers at Grades 1 and 2 are not routinely reported

- the figures on care settings indicate that pressure ulcers also occur in people receiving care in community settings
- in 2013-2014, people in North Norfolk area appear to over-represented in the pressure ulcer population (50% of Grade 3 and Grade 4 pressure ulcers recorded), possibly because the population includes a higher proportion of people at risk
- in 2013-2014, the NEL CSU attributed a reduction in the number of pressure ulcers being reported to increased staff awareness, improved risk assessment and/or provision of pressure relieving equipment
- each CCG has an ambition to reduce the number of 'avoidable pressure ulcers' in their population and take action to achieve this through: instigating Task & Finish Groups and Pressure Ulcer Validation Meetings; funding specialist Tissue Viability Nurses; insisting on the systematic adoption of 'Root Cause Analysis' and pressure ulcer screening tools; application of a CQUIN; and working together to develop a "Pressure Ulcer Strategy for Norfolk"
- ***the overall trend in the numbers of pressure ulcers is upward***

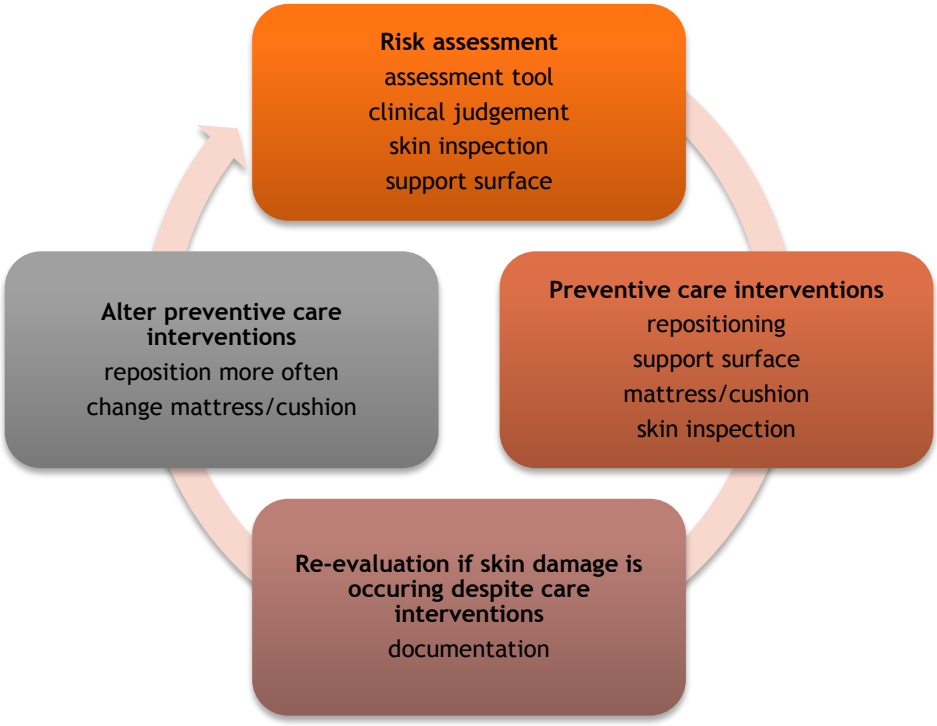


Figure 3. The Wheel of Prevention

Source: Guy H (2012) Pressure ulcer risk assessment. *Nursing Times;* 108: 4, 16-20

1.5 Preventing pressure ulcers

We carried out a literature review of the evidence on what is most effective in preventing pressure ulcers (see Figure 3). Having found over 300+ publicly available abstracts, papers, reviews[1] and guidance and clinical guidance, the strongest evidence points to the following as significant factors:

- the quality of assessment of pressure ulcers and the quality of care planning
- the positioning of a person and re-positioning
- on-going monitoring of the pressure ulcer, the evaluation of interventions and the quality of care delivered
- there is some good evidence on the superior effectiveness of High-Spec Foam Mattresses. Alternating-Pressure Mattresses are widely used but the evidence is vague

We used these findings to inform the focus of our investigations.

[1] National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. (2014) Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Perth; Australia.

2. How we did this

2.1 Developing our approach

The project commenced in August 2015 when a Project Group was established. The group consisted of a project officer and volunteers with a range of expertise (see Page 3) and an interest in pressure ulcer prevention and care. The Project Group met together at least monthly up to and including October 2016. Between August 2015 and February 2016 the group focused on information gathering, reviewing the existing evidence and refining a methodology.

We used a mixed-methods approach to this piece of work, which included desk research, a review of the literature on evidence of what works in pressure ulcer prevention, and care, stakeholder engagement and face-to-face semi-structured interviews with care home staff.

The activities of the group included:

- meeting with various stakeholders to develop knowledge and understanding of the service
- meeting with commissioners of the Integrated Community Equipment Services (ICES) - from both Norfolk County Council adult services and Clinical Commissioning Groups
- conducting a visit to the Norwich depot of the Integrated Community Equipment (ICES) service provider
- requesting data from lead commissioners on pressure-relieving equipment supplied to users, to inform the development of the project
- requesting and considering data on service user feedback
- attending training sessions on pressure ulcer prevention, care planning and treatment to gain up-to-date knowledge
- carrying out a literature review on the effectiveness of pressure-relieving equipment in the prevention and treatment of pressure ulcers
- completing a desk-based review of Clinical Commissioning Group reporting of pressure ulcers as Serious Incidents
- meeting with senior clinical leaders of community nursing services in Norfolk, representing both Norfolk Community Health & Care Trust and East Coast Community Healthcare
- meeting with a Research Nurse contributing towards a national randomised-controlled trial within community hospitals, aiming to compare the effectiveness of High Spec Foam Mattresses with Alternating Pressure Mattresses
- meeting with community matrons and tissue viability nurses
- meeting with CCG care home lead commissioners
- visiting care homes to interview staff

These activities culminated in an interim report together with a concise action plan created in March 2016 (see Appendix 1) and shared with Healthwatch Norfolk's Quality Control Panel.

During the lifetime of the project, local commissioners asked if a representative of Healthwatch Norfolk would like to participate on the Integrated Community Equipment Service Commissioning Board and one of the volunteers from the Project Group attends.

2.2 Population of interest

Following our initial meeting with the commissioners of the Integrated Community Equipment Service, we requested and were supplied with non-commercially sensitive information as to the type and quantity of pressure-relieving equipment supplied in Norfolk and the recipients of equipment. This information told us that a significant proportion of pressure-relieving equipment was being supplied to care homes in Norfolk. This informed our decision to focus on pressure ulcer prevention in care home residents and the associated use of pressure relieving equipment. In particular, in view of the items of equipment supplied, there was a strong suggestion that the equipment was intended for older people with complex health needs and/or frailty.

As a local Healthwatch, we are aware that care homes receive many inspections and enquiries and we wanted to encourage care homes to participate. We also felt that care homes were likely to have a high level of expertise and wide experience of managing pressure ulcers. To this end, we decided to adopt a positive approach to our engagement with care homes, framing this work as a desire to seek out good practice in pressure ulcer prevention and care.

A list of all care homes where beds are commissioned and/or funded by either the local authority or the NHS was obtained and filtered to lift out homes providing residential care for older people. Care homes providing specialist care for children, young people and/or people with learning disabilities were excluded as were homes offering only nursing care. Each project group member was assigned a locality of Norfolk aligned to the West, North, South, East or Norwich areas in which to conduct visits.

A letter of introduction was issued, asking care homes to contribute to a project seeking to gather good practice in pressure ulcer prevention and care. The letter was followed up by a telephone call (often several) and a mutually convenient date arranged for the investigators to meet with the care home manager or other senior member of staff. Meetings with care homes staff were conducted between April and September 2016.

2.3 Semi-structured interviews

A comprehensive review of the evidence-based literature was conducted to identify:

1. Best practice in pressure ulcer prevention
2. Best practice in pressure ulcer care and treatment
3. The most effective equipment

The outcome of the review ensured that the investigators were suitably knowledgeable and that interview questions were relevant and informed (see Appendix 2) and included:

- induction and mandatory training on pressure ulcer prevention and care for care staff
- assessment of skin integrity, tools used and actions taken
- care planning for the resident with a pressure ulcer, monitoring and review
- involvement of community services including community nursing teams and the supply of pressure relieving equipment by the Integrated Community Equipment Service
- care of the resident and the resident's pressure ulcer, repositioning

The investigators also asked the care home staff if they wished to describe any other barriers to providing good pressure ulcer and to highlight examples of their own practice that they considered to be good, or where particularly proud of. During the interview, the investigators took notes that were later entered onto a spreadsheet for safe storage and analysis.

2.4 Ethical considerations

In view of the approach taken, which encouraged an honest and open discussion, participants were assured of confidentiality and that any verbatim quotations would be anonymised. Care home staff were further assured that any information gathered would only be used for the purposes of this project and would be destroyed upon completion.

2.5 Analysis

An initial contents analysis was conducted in April 2016 to identify and list recurring categories of answers and the initial categories were later refined. A contents analysis was used to categorise and count recurring terms and words used by care home staff in their responses.

2.6 Participants

Between April and September 2016, 96 care homes in Norfolk were contacted and members of the Project Group met with Managers and staff at 45 care homes across the county.

2.7 Limitations

Whilst we took all possible steps to mitigate any limiting factors, it is likely the following will have an affect on the completeness and transferability of our findings:

- We could only meet with staff in those care homes agreeing to participate in the project: out of the care homes we contacted we visited 45
- Practical considerations limited the number of care homes that we were able to visit i.e. time constraints and financial resources

- We acknowledge that our findings present a snapshot in time of reported pressure ulcer prevention practice and that the findings may not be representative of all care homes in Norfolk
- Only a minority of the care homes we visited provided nursing care as a well as residential care, hence our findings do not necessarily apply to pressure ulcer prevention in nursing homes
- We chose to focus on care homes providing care for adults and older people with health and social care needs, and/or physical disabilities and/or mental health needs; so our findings do not therefore represent pressure ulcer prevention practice in homes providing care for children and young people or children and adults with a learning disability
- We did not interview residents with pressure ulcers as part of our methodology because it was deemed inappropriate and intrusive but recognise the findings do not give the resident's perspective on pressure ulcer care
- We didn't receive all the information that we requested on the numbers and severity of pressure ulcers because the holders of the information – NHS commissioning and provider organisations in Norfolk - did not respond to our repeated requests and therefore are findings are not as complete or contextualised as we would wish

3. What we found out

3.1 The Integrated Community Equipment Service

3.1.1 Commissioning arrangements

In 2013 a national directive dictated that all equipment services be 'integrated' at the upper-tier local authority level. For Norfolk, this is the Integrated Community Equipment Service (ICES) which is jointly commissioned by Norfolk County Council and Norfolk's five CCGs. An ICES Management Board oversees the commissioning of the service (see *Figure 4*). Norfolk County Council is the lead contractor through a Section 75 agreement and manages the contractual performance of the service.

The service in its current form was tendered in 2012 and commissioned to commence in April 2013 jointly by Norfolk County Council and four CCGs, with Great Yarmouth and Waveney CCG later joining the integrated arrangements. Under these arrangements, a Norfolk-wide service provides for the Great Yarmouth areas and now, the Waveney area also.

A Professional Advisory Group comprised of health and social care professionals advises on the clinical, health and social needs of service users and the types and function equipment to be provided. This group regularly reviews the types of equipment that are available as well as assessing and recommending new equipment or improvements as required. A highly specialised Occupational Therapist provides expert clinical input to the service. A Specialist Equipment Panel convenes regularly to process applications for specialist or unusually expensive equipment items (i.e. above £500).

There are a number of Local Equipment Groups (LEGs) comprised of local health and social practitioners and service users, providing a channel through which service users can feedback on their experiences and suggest improvements.

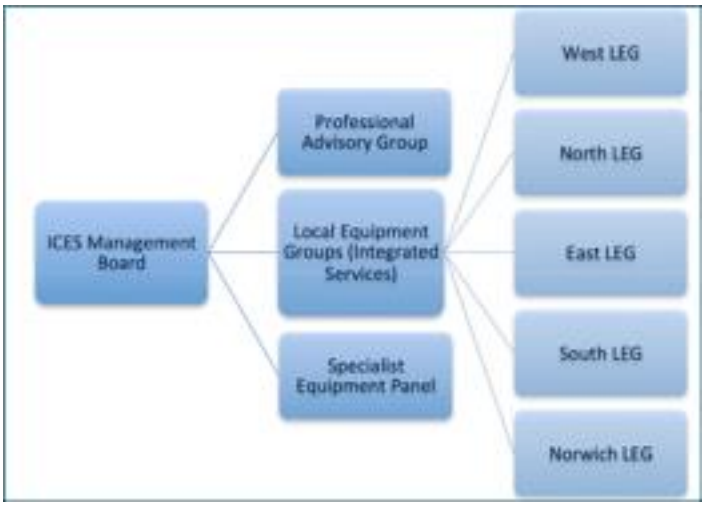


Figure 4. Governance structure of the Integrated Community Equipment Service

3.1.2 Service provision

NRS Healthcare currently provides the service. The central depot for the county service is in Norwich, with several satellite stores at acute and community hospital sites. The service operates from 8am to 6pm Monday to Friday and offers a 24-hour out-of-hours

service for emergencies.

NRS Healthcare warehouse, deliver, install, collect, clean, refurbish and recycle equipment and turn around approximately 4,000 items of equipment every week. The service also carries out routine repair and maintenance of long-loan equipment, for example, carrying out 6 month and 12 month checks on ceiling hoists and other equipment that involves home adaptation services as well. NRS Healthcare operates a 5-day and 10-day repair service. Around 240 items of equipment are kept in stock at the central depot, logged on a central database.

There are over 20 delivery technicians and drivers working in various patches of the county who deliver equipment to service users. Delivery drivers and technicians are required to have an enhanced DBS check[2] and are trained in the setting up and use of equipment, in customer care, health and safety and safeguarding. Delivery drivers and technicians are required to wear identity badges when delivering equipment. They have a responsibility to set the equipment up and give verbal and written instructions about its use, maintenance and what to do if problems arise.

3.1.3 Prescribers of equipment

At the time of writing, there are 2,500 health and social care professionals currently registered as 'prescribers' of equipment, having password-protected access to the online portal, product catalogue and ordering system. These individuals may hold different levels of authority in respect of the actual ordering and purchasing of equipment; some individuals require a further sign-off by a more senior prescriber or manager when placing an order for equipment. When establishing the service, the NRS Healthcare roadshow delivered 54 training workshops to health and social care prescribers. Pressure relieving equipment such as foam and alternating pressure mattresses, mattress overlays, cushions, wedges and boots and elbow protectors are examples of equipment that are often used in pressure relief. In 2014-15, prescribers of equipment requested 14,356 items of pressure-relieving equipment in the 12-month period.

3.1.4 Service user feedback

NRS Healthcare collects service user feedback and satisfaction scores. This is done through the use of a feedback form that is left by Delivery Technicians when they deliver equipment and can be returned by post if the service user so chooses. The service also runs a customer service centre which receives calls and processes queries, requests, concerns and complaints from prescribers and service users alike.

[2] Criminal Records Bureau (CRB) checks are now called Disclosure and Barring Service (DBS) checks. An employer may need to check someone's criminal record if they apply for certain jobs or voluntary work such as working with children, vulnerable adults or in healthcare or to foster or adopt a child, for further information see https://www.gov.uk/disclosure-barring-service-check/overview

3.2 Findings from semi-structured interviews

Between April and September 2016 members of the Project Group met with the managers and staff of 45 care homes. This section describes the responses we received to the questions we asked about pressure ulcer prevention and management.

3.2.1 Training

Rationale for asking about training: the NPUAP[3] Guidelines state the importance of 'teaching the individual/significant others about healing process, signs of deterioration'

We asked care homes about the inclusion of pressure ulcer management in their induction training for new staff (Table 1) and in their mandatory training schedule (Table 2).

Table 1

Responses of 42 care homes to the question "Does your induction training include pressure ulcer management?"

Response category	Number of responses
Yes, its part of our in-house induction programme that all new staff do	20
New staff are trained through doing their Care Certificate which includes a component on pressure ulcer management	9
No, not specifically; new staff learn through shadowing other staff for a period of time	7
No, not specifically but new staff are trained in manual handling	6

Those care homes who said that pressure ulcer management was part of their induction training for new staff gave some examples of the content:

- Intensive training on repositioning
- An emphasis on skin care
- Pressure ulcer risks
- Recognition factors
- Continence
- Prevention of pressure ulcers
- Correct lifting, moving and handling residents with fragile skin
- Using specific assessment tools such as the Waterlow score, NorseCare, body maps

[3] National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. (2014) Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Perth; Australia.

Table 2

Responses of 45 care homes to the question "Is pressure ulcer management training (and/or updates) included in your mandatory training schedule – and if so, what is included and how often?"

Response category	Number of responses*
Yes, mandatory schedule includes pressure ulcer management through classroom/group/team in-house training or update session	16
Yes, mandatory schedule includes pressure ulcer management through a mix of in-house and externally provided training packages	10
Yes, thorough training provided by community nurses and/or the tissue viability nurse	14
Yes, via an online e-learning module	3
No, not for all care staff; only for our pressure ulcer lead/champion who cascades to other care staff	4
No, specific pressure ulcer training is included in our mandatory schedule	3

*Note: Total will not sum 45 responses: 6 care homes relied on training provided by Community Nurses and Tissue Viability Nurses delivered 'in-house'; 1 care home provided in-house mandatory training solely through an online e-learning module

Regarding the frequency of mandatory updates, 16 care homes said they offered mandatory training updates on pressure ulcer management on a yearly basis and 3 said training updates were offered on a rolling programme (36 homes did not describe the frequency of updates).

Thirteen out of the 14 care homes who told us that training on pressure ulcer management was provided by the community nurses or the tissue viability nurse were homes within the eastern locality area where community services are provided by East Coast Community Healthcare. One further home was dual-registered and employed its specialist tissue viability nurse on a part-time basis who provided in-house pressure ulcer management training to the care home care workers.

Twenty seven care homes (out of a potential 45) said that pressure ulcer management was included in both their induction training for new staff *and* in their mandatory training schedule.

3.2.2 Assessment

Rationale for asking about assessment: the NPUAP Guidelines state that assessment is a key factor in deciding what equipment - if any - is required, in preventing or treating the pressure ulcer. 'The Wheel of Prevention' (Guy, 2012) includes risk assessment as a key step. The Project Group also wanted to know who i.e. which member of the care team, is assessing the resident's skin, how they were doing the assessment and what happened if the assessment indicated a change in the integrity of the resident's skin.

We asked care home staff how their staff assess the condition of an individual's skin. Table 3 sets out the different responses given by staff.

Table 3

Responses of 45 care homes to the question "How do your staff assess skin integrity?"

Response category	Number of responses*
Observing the resident's skin	19
Looking for signs of pressure ulcers	11
Looking for red patches	8
Doing an assessment	7
Doing a 'body scan' or 'full body check'	5
Checking residents	4
Examination of residents	1
Staff are alert for signs	1
Respondents did not describe 'how'	5

*Note: Total will not sum 45 responses as some staff gave more than one example of how their staff assess resident's skin integrity

Some care homes went on to describe when staff assess the skin integrity of a resident. These included assessing skin when the resident is admitted to the home (11 care homes said this), including their very first admission or when re-admitted following discharge from hospital. Some staff said that a resident is checked when giving personal care (8 said this) such as helping a resident to bathe, or dress or assisting them to bed in the evening and 3 said a skin assessment was done every day.

We asked care home staff about any particular tools they used to assist them in assessing skin integrity. Their responses are shown in Figure 5 overleaf. Two thirds were using the 'Waterlow' assessment tool but 6 care homes did not name any specific tool (4 of these were in the West Norfolk area). Some care homes gave us paper copies of the tools they use to assess skin integrity and to record any changes and these can be found in Appendix 3. Three care homes told us that they take photographs (having obtained the necessary permissions to do so) of a resident's skin as a means to assess, record and monitor skin integrity. Nine homes said they use the hydration and nutrition assessment tools called Malnutrition Universal Screening Tool (MUST).

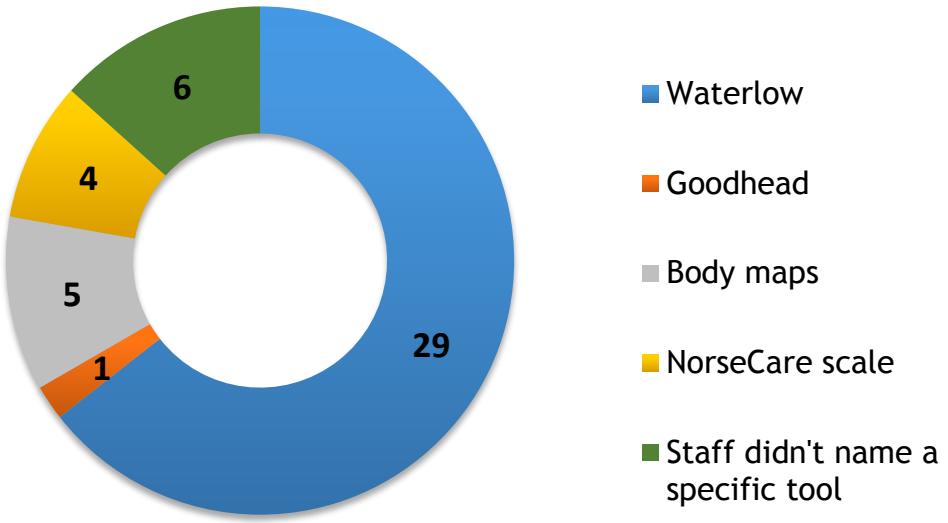
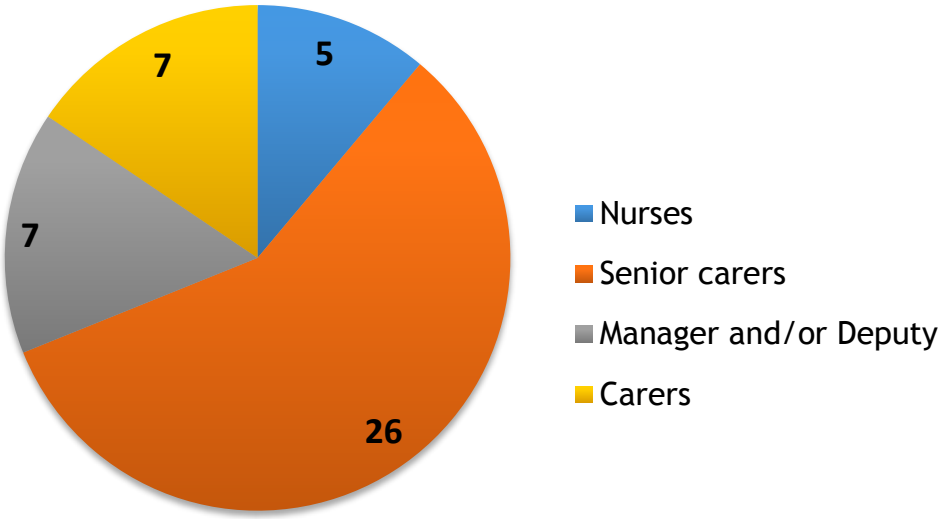


Figure 5. T*he responses of 45 care homes to the question "What assessment tools are your staff using?"*

Care homes were also asked about which member of staff assesses their residents' skin – see Table 4.



*community nurse or a trained nurse on-site

Figure 6. *Responses of 45 care homes to the question "Who is assessing the person with a pressure ulcer or deemed to be at risk of developing a pressure ulcer?"*

Figure 6 shows that the senior carer is the person responsible for assessing a resident with a pressure ulcer or deemed to be at risk of developing one in just over half of the care homes we visited. At 5 care homes we were told that nurses assess a resident, with nurses being described as either the community nurse or a registered nurse on site in the

case of dual-registered care homes. We asked staff to tell us what happens when a member of staff has identified a pressure ulcer and the responses we received are described in Figure 7.

When staff identify a pressure ulcer, it is…

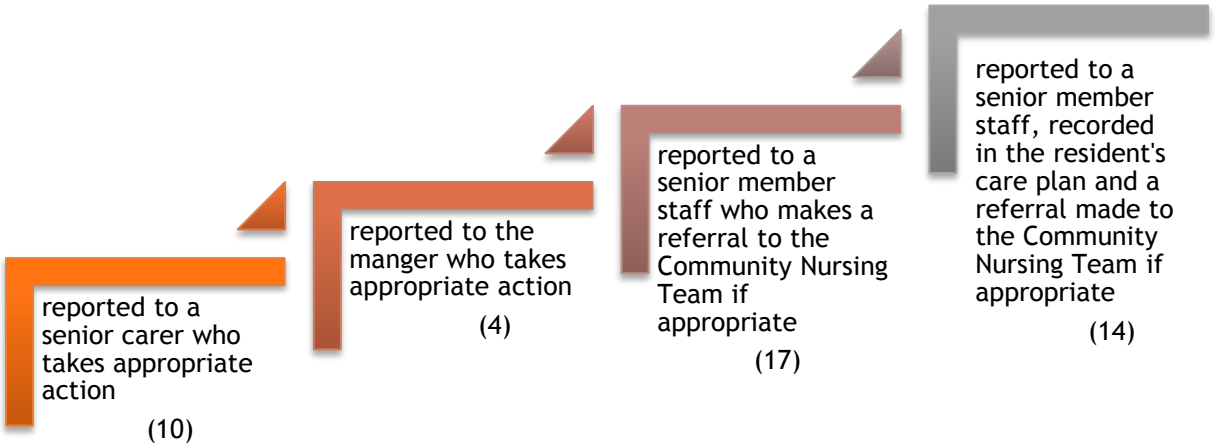


Figure 7. *The responses of 45 care homes to the question "What happens if a member of staff identifies a pressure ulcer?"*

The responses we received to our questions on the practices in place regarding the assessment of skin and pressure ulcers tell us that all care staff report any changes in the skin integrity of the resident although the reporting route varied. Two care homes told us that they also carry out a Root Cause Analysis of the pressure ulcer in addition to reporting, recording and referring the pressure ulcer to community nurses. Two will take photographs of the pressure ulcer.

3.2.3 Planning and reviewing care of a resident with a pressure ulcer

Rationale for asking about who is involved in planning and reviewing care: the NPUAP Guidelines state that a comprehensive initial assessment including equipment needs is a key step in pressure ulcer care. The Project Group also wanted to understand the process of planning, monitoring and reviewing the pressure ulcer – in particular the 'monitoring of healing' - along with how often this done and by whom. The care home is the residents 'home' and our questions follow the basic assumption that the residents of care homes receive the same equality of access to community services as any other resident of the county e.g. community nursing, physiotherapy, occupational therapy and the Integrated Community Equipment Service We therefore asked how community services are involved in the care of residents with a pressure ulcer.

Care home staff were asked how long community services take to respond to an initial contact or referral about a resident with a pressure ulcer (or suspected pressure ulcer) and the type of response the care homes receives - see Table 4 below.

When a referral is made to the community nursing service, 15 care homes said they receive an initial response on the same day and a further 16 said within a day/24 hours. Six care homes indicated it could take several days to receive a response but 8 did not give details on the length of wait.

Table 4.

Responses of 45 care homes to the question "If you make a referral to community services, how long do you have to wait for a response?"

Response category	Number of responses
Response on the same day	15
Response 'within 24 hours'	6
Response next day	10
Response within 2-3 days	5
Response takes up to 4 days	1
Staff did not specify how long they wait	8

We asked what services generally do when they respond (see Table 5 overleaf) and if community nurses are involved in care planning for residents with a pressure ulcer (see Figure 8 also overleaf).

Table 5

Responses of 41 care homes to the question "When services respond, what will they do?"

Response category	Number of care homes*
Community nurse telephones the care home	1
Community nurse visits the resident and assesses them	38
Community nurse put a care plan in place	6
Community nurse will advise staff on pressure area care	13
Community nurse will prescribe and order pressure relieving equipment	14
Community nurse will involve the Palliative Care Team if appropriate	1
Tissue viability nurse will visit the resident and advise	4
Staff did not specify what services do when they respond	2

*Note: Total will not sum 45 responses as some staff gave more than one example of how community services respond to a referral

Seven care homes told us that they would also contact the resident's GP who will be willing to get involved. A further two said that their resident's local GP surgery was unwilling to get involved in pressure ulcer care and generally provide a poor service.

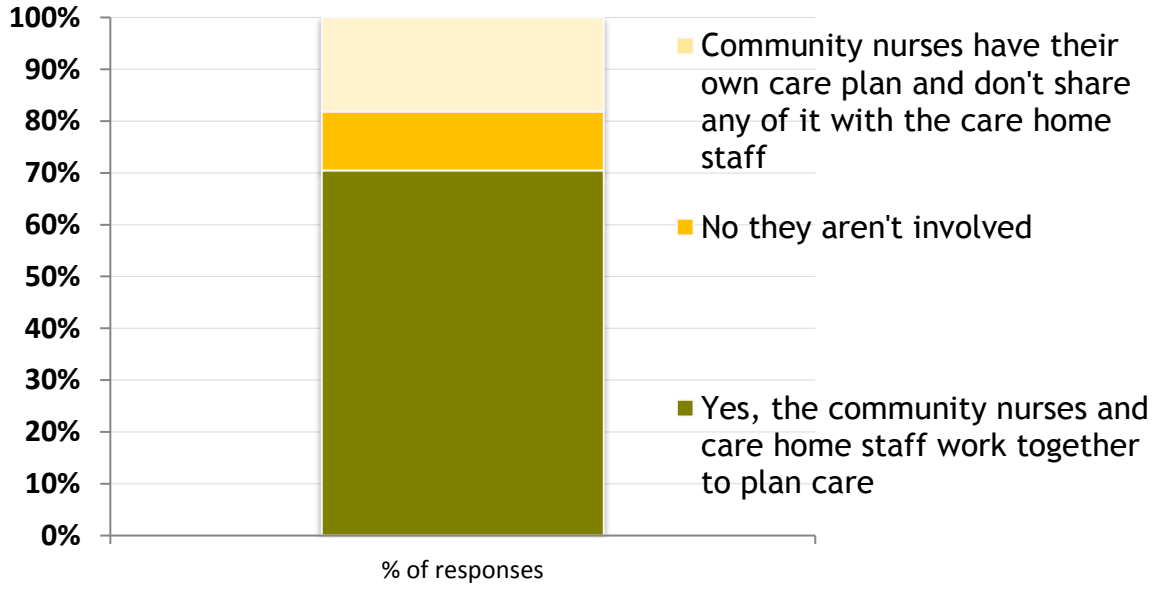


Figure 8. *Responses of 44 care homes to the question "Are community nurses involved in care planning?"*

We received a mixed picture regarding the involvement of community nurses in care planning for residents with a pressure ulcer. When we asked this question, we held an assumption that there would be one pressure ulcer care plan in place. As we progressed in our interviews with care homes it became apparent that two care plans are created and maintained separately. This also raises the possibility that care plans may not even be similar. In answering these questions, care home staff may have been referring to their own care plan for the resident *or* that held electronically by the community nurses *or* both.

In a majority of homes (70%), the community nurse and the care home staff will work together to plan care (Figure 8). Around 20% of care homes said that the community nurses will be involved in care planning but they create a care plan that is not shared with the care home staff.

Similarly, we received a mix of responses to a question asking who holds *responsibility* for developing a pressure ulcer plan for the resident, as shown in Table 6 below. The responses to both these questions reveal a mix of practice regarding the planning of care for a resident with a pressure ulcer and who takes responsibility for different aspects of care.

Table 6

The responses of 45 care homes to the question "Who is responsible for developing a pressure ulcer care plan?"

Response category	Number of responses
Community nurse develops a pressure ulcer care plan	13
Community nurse develops the pressure ulcer care plan and the care home staff incorporate specific pressure ulcer care into the resident's existing care plan. The Community Nurse provides verbal feedback and instructions – either voluntarily or on the request of care home staff.	7
Community nurse develops the pressure ulcer care plan and writes specific pressure ulcer care instructions in the resident's existing care plan - either voluntarily or on the request of care home staff.	6
Community nurse develops the pressure ulcer care plan and care home staff use their own initiative to incorporate specific pressure ulcer care instructions into the resident's existing care plan. These initiatives include staff shadowing the Community Nurse when care/treatment is given to the resident, asking for instructions and using their own experiences of caring for residents who have a pressure ulcer.	6
Senior staff in the care home e.g. senior carer, deputy/assistant manager or manager develop the pressure ulcer care plan.	13
Qualified nurse on site* develops the pressure ulcer care plan	4

* In the case of dual-registered care homes, a Registered Nurse will be required to be on site 24/7. In some care homes, the Manager happens to be a Registered Nurse.

Staff told us that when a community nurse develops a pressure ulcer care plan for a resident it will be in an electronic format held on the remote server of the community services provider. This is the case for electronic health records held by both community service providers in Norfolk, Norfolk Community Health and Care Trust (NCH&C Trust) and East Coast Community Trust (ECCH).

Only authorised employees of the community services have access to the respective systems via an electronic identity and password. This is standard practice within NHS organisations and ensures that patient-identifiable, personal health information is kept secure and confidential. This also means that care home staff cannot access the electronic pressure ulcer care plan created by the community nurses and may not know what treatment or care the nurse has given when visiting the resident. There were several instances of community nurses not sharing information or indeed even recording the visit.

Staff also told us that every resident in a care home has an individual care plan. This is standard practice and includes many aspects of that resident's care and preferences. Staff said that specific pressure area care instructions will be incorporated into the resident's own care plan and if community nurses give specific instructions these will also be incorporated into the resident's care plan held by the care home.

We asked care home how the care plan that is put in place is monitored and reviewed; the responses we received are shown in Figure 9 below.

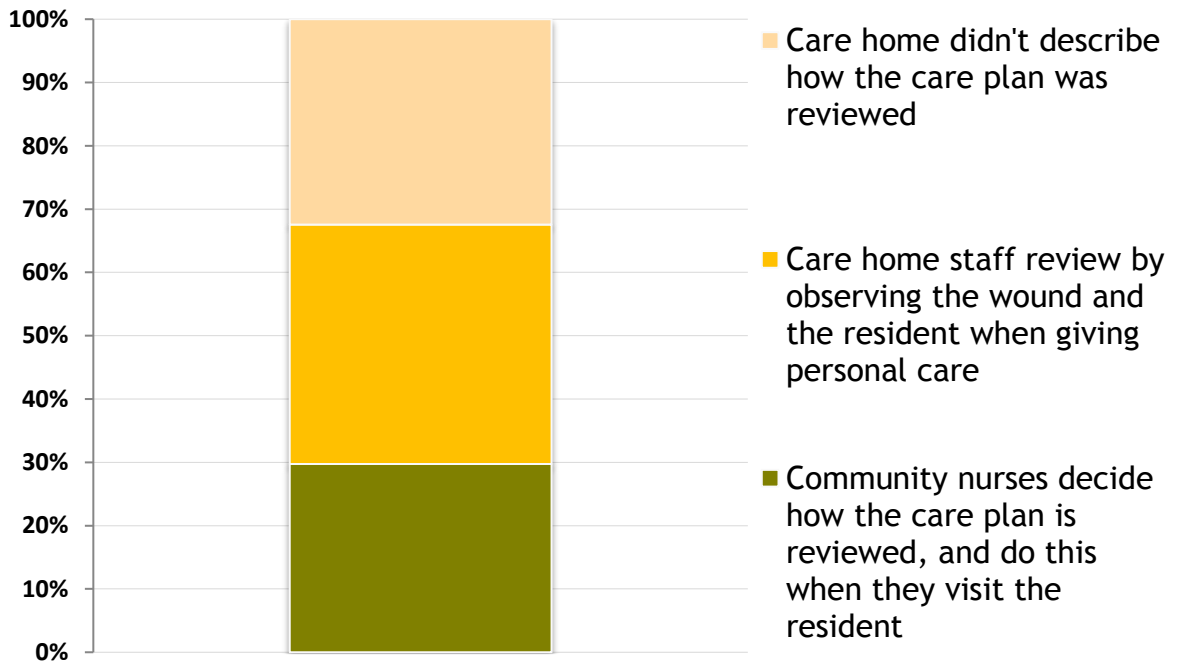


Figure 9. *Responses of 37 care homes to the question "How is the care plan monitored and reviewed?"*

In some care homes, care staff review care by observing the resident and their skin when giving personal care and other homes told us that the community nurse decides how the care plan is monitored and reviewed, doing this when they visit the resident.

The responses shown in Figure 10 below reveal that, just as the responsibility for planning for pressure ulcer care can be split between care home staff and community nursing staff or seen as the responsibility of the community nurses, so is the responsibility for monitoring and reviewing the care plan. It is important here to remember to distinguish between the pressure ulcer care plan developed and held electronically by the community nursing teams and the care home's own – often paper based - care plan for the resident.

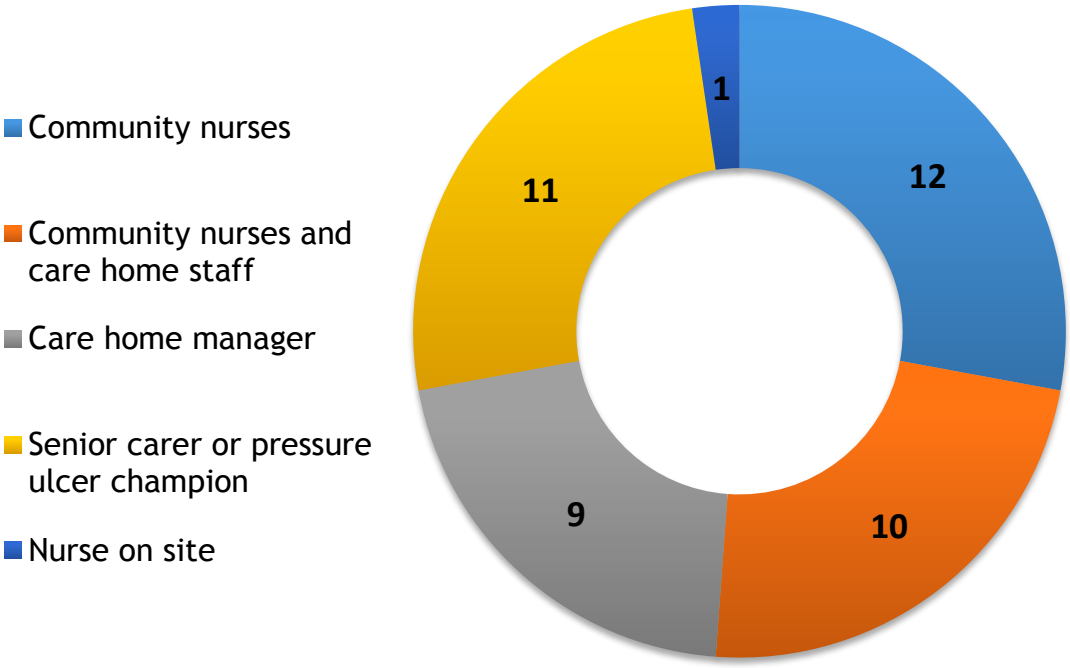


Figure 10. *Responses of 43 care homes to the question "Who monitors and reviews the care plan?"*

Seven care homes told us that a member of their staff held the role of "Pressure Ulcer Champion" and gave examples of what a Pressure Ulcer Champion does:

- Keeps up to date with new developments in pressure ulcer prevention and care and is responsible for cascading updates to all members of staff
- Assesses skin integrity if a change in skin integrity is reported
- Reviews the resident's care plan; adding and updating information on pressure ulcer care and monitoring
- Undertakes further or specialist training in pressure ulcer prevention and care; delivers pressure ulcer training to other care workers
- Sources the most appropriate pressure ulcer assessment or monitoring tools and other resources such as body maps, repositioning guides and turn charts and helps to ensure all members of staff understand how to use them
- Takes a specific responsibility in monitoring repositioning charts or pressure ulcer logs
- Helps the manager to undertake pressure ulcer audits e.g. monthly

3.2.4 Care of the resident

3.2.4.1 Repositioning

Rationale for asking about repositioning, how, when and by whom: Repositioning is an integral component of pressure ulcer prevention and treatment; it has a sound theoretical rationale, and is widely recommended and used in practice[4]. There is good evidence that the type of support surface plays an important role e.g. surfaces which redistribute areas of pressure. Compatibility with the care setting is a factor in choice of repositioning equipment and whilst the frequency of positioning is not prescribed in the literature, frequency needs to be considered alongside other negative effects of turning such as sleep disruption, increased pain and, for nurses, musculoskeletal injuries. Repositioning in some form is recommended in all clinical guidelines though implementation is probably variable and highly dependent on the available resources (particularly staffing levels). The literature also makes many references to obtaining the advice/instructions of specialists including tissue viability specialists and seating specialists.

We asked care home staff if instructions on repositioning a resident are put in the resident's care plan; their responses are shown in *Figure 11*. Out of 45 care homes, 44 said that there would be instructions on repositioning a resident in the resident's own care plan. It is interesting to note that 37 care homes (82% of our sample) also told us that a specific tool would be used for this, such as a 'turn chart' or 'repositioning chart' (please see Appendix 4 for examples). One home said that care staff are given verbal instructions regarding repositioning.

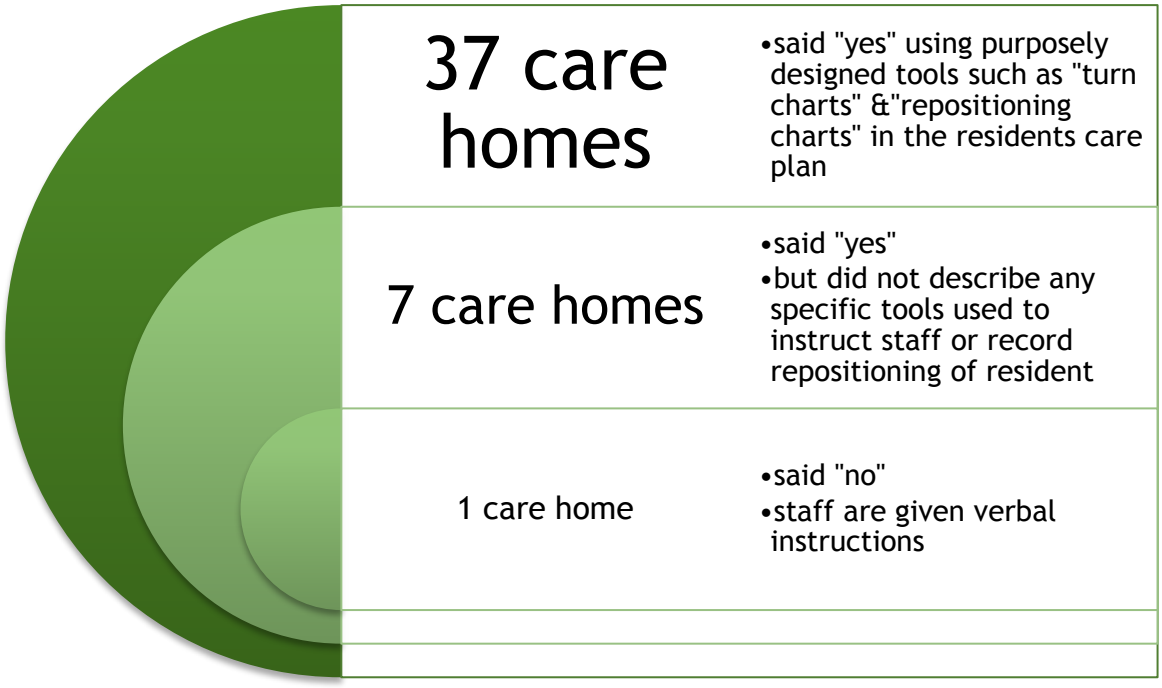


Figure 11. *Responses of 45 care homes to the question "Are there instructions on repositioning in the resident's care plan?"*

[4] Gillespie, B.M et al (2014) *Repositioning for pressure ulcer prevention in adults (Review)* Cochrane Database Syst Rev. 2014 Apr 3;(4)

We also asked "how are residents repositioned?" and in answer to this question:

- **24** care homes said "according to the instructions in the resident's care plan/turn chart/repositioning chart"
- **18** care homes described examples of how a resident might be repositioned
- **3** care homes said "according to the instructions" and described examples
- **4** care homes said "as needed" without further explanation

Table 7 below shows the examples that care home staff gave when describing repositioning.

Table 7

Examples of how residents might be repositioned, as given by 21 care homes

Movement	Positioning	Equipment
If the resident is seated, encouraging them to stand with help from carers	A very fragile resident cannot always be moved into a different position so a change of elevation is used	Use of standing aids
Encouraging residents to walk to the toilet, bathroom or to the dining for meals, with help from carers	Turning a resident in bed from one side to their other side	Use of hoists
Assist resident from bed into an armchair	Tilting a resident's bed	Using wedges; "wedging"
Assist a resident from an armchair into a wheelchair	Repositioning a resident's limbs e.g. legs, feet, arms	Using equipment to help 'tilt' a resident's body
Assist a resident from a wheelchair into bed	Carers assist residents in wheelchairs to change the position of their limbs	Every resident has an air-flow mattress on their bed
Encouraging a seated resident to lie on their bed on their side for a couple of hours in the afternoon		Use of 'Repose' cushions in the chairs of residents who are seated a lot during the day
Encouraging seated residents to "wiggle' around		Using a slide-sheet to turn a resident in bed from one side to their other side
Encouraging participation in seated exercise sessions		Using bolsters to support limbs of residents who are in bed
Encouraging residents who are able to go for a walk outside the building		Use of dynamic mattresses

We enquired about the frequency of repositioning, the member of staff assisting with repositioning and whether or not it is recorded in the resident's care plan. The responses are shown in Tables 8 and 9.

Table 8

Responses of 45 care homes to the question "How often [are residents repositioned]?"

Response category	Number of responses*
Residents are repositioned 2 hourly during the day	16
Residents are repositioned 4 hourly during the night	10
The frequency of repositioning will be according to the care plan/turn chart	20
Staff did not say how often residents are repositioned	7

*Note: Total will not sum 45 care homes. In some care homes, residents were repositioned 2 hourly during the night and during the day

Table 9

Responses of 45 care homes to the question "Who [repositions a resident]?

Response category	Number of responses*
Two members of staff [two carers]	8
Members of staff; carers when giving care	29
Staff did not say who repositions a resident	18

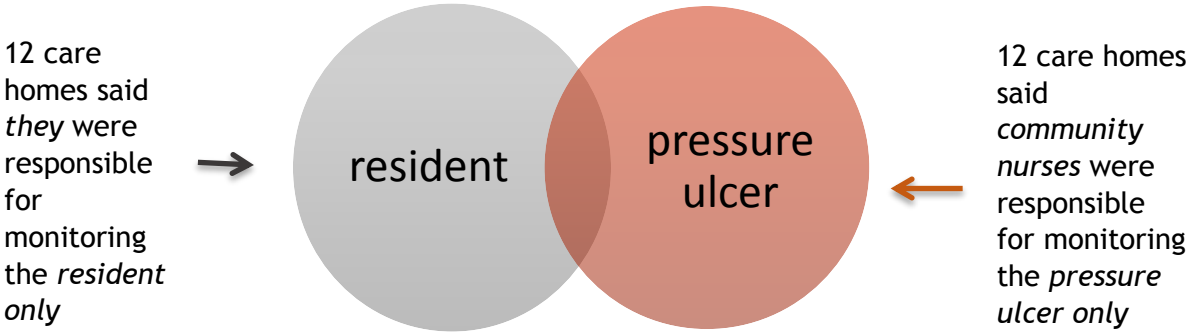
*Note: Total will not sum 45 care homes

Fifteen (15) care homes told us that every time a resident is repositioned, this action would be recorded in the resident's care plan or on the turn/repositioning chart.

3.2.4.2 Monitoring the resident

Rationale for asking about the monitoring of the resident: the NPUAP Guidelines state that assessment is a key factor and that health and care workers should expect to observe some signs of healing within two weeks. There is also good evidence on observing and reporting signs of deterioration. With regards to the quality of care the resident is experiencing from care home staff and other health and social care workers, the Project Group wanted to know who is responsible for the monitoring the resident and their pressure ulcers in respect of the resident's comfort, dignity and the management of pain and other symptoms.

We asked care home staff who was responsible for monitoring the resident and their pressure ulcer. The responses of care home to our question on monitoring of the resident and their pressure ulcer are displayed in *Figure 12* below.



4 care homes said that *community nurses* were responsible for monitoring both the resident and the resident's pressure ulcer
23 care homes said *they* were responsible for monitoring both the resident and the resident's pressure ulcer (4 of whom said the community nurse will monitor the pressure ulcer as well)
5 care homes said that the monitoring of the resident and their pressure ulcer was done *jointly* between the care home staff and the community nurses

Figure 12. Responses of 44 care homes to the question "Who is responsible for monitoring the resident and the pressure ulcer?"

Two care home managers told us that they take photographs as a monitoring tool. One care home manager described how it is their common practice to take photographs of the pressure ulcer weekly and monthly in addition to monitoring the resident daily or at every intervention. All residents will have a Waterlow, BMI and skin integrity check within 24 hours. Those admitted to this particular care home from hospital are checked over as soon as possible and any skin changes noted. Notes on the skin integrity (with photographs if appropriate) are also recorded on any resident going into hospital, as a pro-active measure.

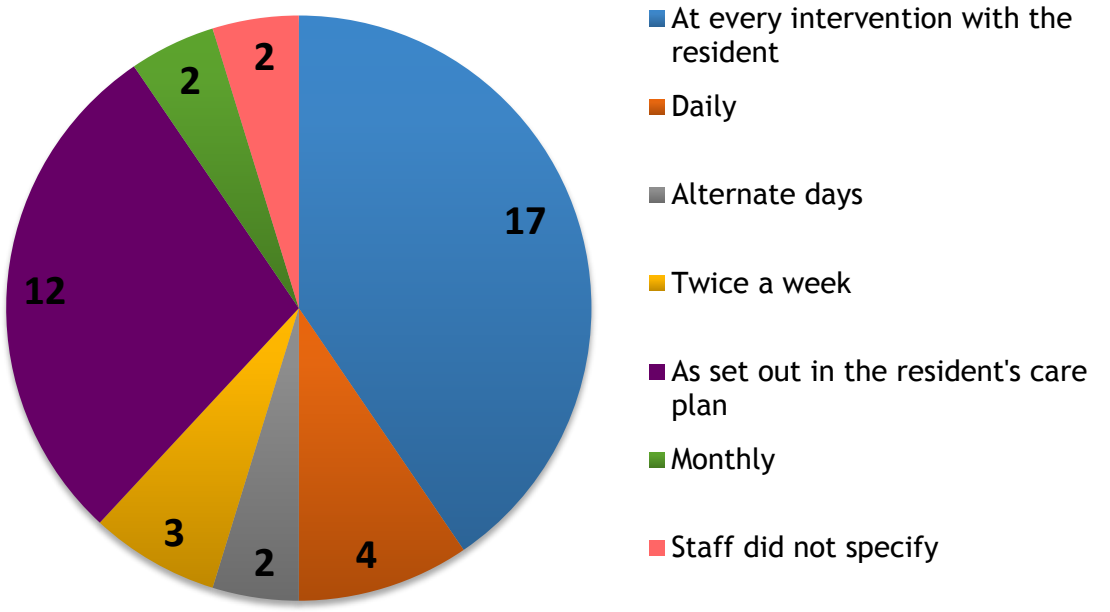


Figure 13. Responses of 42 care homes to the question "How often is this done?"

Eleven care homes told us that the frequency of checking on the pressure ulcer itself depends upon the frequency of the community nurse visits, as the community nurse will be checking the pressure ulcer when they visit the home to see the resident.

3.2.4.3 Use of pressure relieving equipment

Rationale for asking about the monitoring of the resident: there is good evidence that the selection of appropriate pressure relieving equipment is a key factor in pressure ulcer prevention and treatment for example, use of manual handling equipment, wheelchair seats, bed elevators, pressure redistribution surfaces, mattresses and overlays, seat tilts, footstools and other positioning devices. A review by McInnes et al[5] concluded that people at high risk of developing pressure ulcers should use higher-specification foam mattresses rather than standard hospital foam mattresses. The relative merits of higher-specification constant low-pressure and alternating-pressure support surfaces for preventing pressure ulcers are unclear, but alternating-pressure mattresses may be more cost effective than alternating-pressure overlays. Medical grade sheepskins are associated with a decrease in pressure ulcer development. A Cochrane review of the evaluation of alternating-pressure devices is given emphasis as a standard, preventive intervention in some areas, but not others, and may vary widely in cost (from less than GBP £1,000 to more than GBP £4,000).

When we enquired about the kinds of pressure relieving equipment residents might be using, several care homes told us that they had purchased their own collection of equipment including mattresses and cushions. Two care homes had invested in high density foam mattresses for all their residents and one told us that a non-plastic mattress cover is a big advantage as plastic sheets, often fitted due to incontinence, exacerbate skin care problems.

[5] McInnes et al (2015) Cochrane Database Syst Rev Apr 13;(4): CD001735

We asked care home staff who decides which equipment would be most effective for a resident and who orders it, with responses shown in Tables 10 and 11 (below). From the responses, it is clear that community nurses make the decision regarding the equipment that would be most effective for an individual resident and some do this in discussion with care home staff. Community nurses are also the chief prescribers of pressure relieving equipment and along with tissue viability nurses and other health professionals such as occupational therapists are ordering equipment for residents in their care, from the Integrated Community Equipment Service provided by NRS Healthcare.

Table 10

Responses of 45 care homes to the question "If a resident needs equipment, who decides what equipment would be most effective?"

Response category	Number of responses
Community nurse	32
Community nurse in discussion with care home staff	6
Tissue viability nurse	3
Care home manager decides	3
Did not specify	1

Table 11

Responses of 45 care homes to the question "Who orders the equipment for the resident?"

Response category	Number of responses
Community nurse	32
Tissue viability nurse	6
Other health professional/clinician	3
Care home provides all necessary equipment*	3
Care home staff via a referral through the SPoA**	1

*These were dual-registered care homes e.g. providing nursing care

**Single Point of Access: this is the "hub" through which community services can be contacted

We asked how long care home staff usually wait for equipment and their responses indicated that it is usually delivered promptly within a day or two, depending on the type of equipment that is being prescribed, see Table 12. There were several positive comments regarding the prompt delivery of equipment and many care homes were happy with the service they received from NRS Healthcare regarding the delivery of equipment prescribed for their residents.

Table 12

Responses of 42 care homes to the question "How long do you usually wait for equipment?"

Response category	Number of responses
Same day if pressure relieving equipment	3
Next day	4
1-2 days	20
Up to 5 days	3
Up to a week	6
A week or longer	1
Depends on the type of equipment	4
Did not specify	1

We also received several comments, however, on the timing of equipment deliveries. Some homes commented on knowing the day of the delivery but not being given a time slot. This meant it was difficult to arrange for a member of staff to be available to greet the delivery driver and accompany them to the resident's room if required, for example in the case of the delivery of a bed or a mattress etc. Some care homes said they did not have sufficient notice of a delivery in order to move and relocate a vulnerable resident i.e. a resident with very fragile skin or existing pressure ulcer, to be ready to receive a new or replacement mattress for example. We were also told that delivery drivers arrive at resident's mealtimes, which could be difficult for staff to manage[6].

Eight care homes said that collection of equipment was a problem for them in that it could take up to 2-3 weeks. This meant that the care home had to store equipment whilst waiting for collection. Some were confused as to why equipment couldn't be collected at the same time that new equipment was being delivered to the care home. Sometimes equipment collection delays meant that a room could not be prepared for use by another (or new) resident, resulting in delayed admissions and lost occupancy for the home and therefore loss of income.

Regarding correct use of equipment, 26 out of 45 care homes said that the NRS Healthcare delivery drivers give full instructions on using the equipment supplied correctly (see Table 13). A further 9 homes said that the correct use of equipment was included in their staff manual handling training as a matter of course. Eight homes said that the person prescribing equipment also gave instructions; for example, the community nurses (4 homes said this), physiotherapists (2 homes) and occupational therapists (2 homes). Four homes said the delivery drives didn't give any instructions to them.

[6] At the time of receiving these comments, we fed them back to the ICES Commissioning Board to communicate to the provider, NRS Healthcare, with the suggestion delivery drivers could call ahead with a delivery time so care staff can move a resident appropriately and/or be prepared to receive a piece of equipment.

Table 13

Responses of 45 care homes to the question "What instructions do your staff receive on using the equipment correctly?"

Response category	Number of responses
NRS Healthcare delivery drivers give full instructions	26
Care home trains staff in using equipment as part of manual handling, pressure ulcer or similar training	9
Community nurses will give instructions	4
Physiotherapists will give instructions	2
Occupational Therapist will give instructions	2
NRS Healthcare delivery drivers don't give any instructions	4
Did not specify	1

Several care homes showed us examples of the equipment charts they use when staff are repositioning a resident and checking that their pressure relieving equipment i.e. mattress, cushion etc are working, at the correct setting for the resident (please see Appendix 5). One care home manager also showed an example of an equipment audit policy and process and said that an equipment audit is conducted every six months to take stock of the equipment in the home and to ensure any that is no longer used or needed (e.g. as a result of a resident's death) is logged to be returned to NRS Healthcare.

3.2.5 Spontaneous themes

Amongst the responses we received, care home staff also gave us feedback on their views and experiences of other aspects of pressure ulcer prevention and care, in addition to the questions we posed. Some themes are positive in nature and some are more negative. Some of these have been alluded to in the previous sub-sections and are presented in Table 14.

Table 14

Spontaneous themes arising from discussions with staff of 45 care homes

	Theme
1	**Care homes are highly motivated to prevent pressure ulcers** Care home staff consider a pressure ulcer to be an unusual occurrence and several told us "pressure ulcers are bad for business". Staff considered only a minority of pressure ulcers to be unavoidable and that pressure ulcers are the result of poor quality care. Care home managers in particular, were keen to stress that a pro-active approach is the best culture to adopt and that managers and senior staff need to be role models in good practice promoting an active approach to pressure ulcer prevention. Encouraging mobility in residents, constant vigilance of skin integrity, good standards of personal care and hygiene, supporting continence and enabling residents to have a good diet were all listed as components of good preventive care.
2	**Residents can be discharged from hospital with a pressure ulcer** Many care homes were disappointed with the quality of care their residents received in acute care settings (hospitals). Several care homes told us that (10 explicitly mentioned this problem) in their experience, pressure ulcers mostly occurred in residents admitted to a hospital ward for any period of time, for even as little as a day. They said that they felt their residents did not receive the same level of care and vigilance on a hospital ward; many were not encouraged to be mobile on the ward in order to manage a falls risk and some were unnecessarily catheterised when they were not exhibiting incontinence. We were told that this happens to residents admitted to the Queen Elizabeth Hospital in King's Lynn and the Norfolk & Norwich University Hospital in Norwich.
3	**Equipment delivery is very good, collection waiting times could be improved** The delivery of pressure relieving equipment by the Integrated Community Equipment provider is prompt and care homes are satisfied with this aspect of service delivery and the instructions they receive from delivery drivers regarding the use of equipment. Unfortunately, **collection of equipment** issued by the Integrated Community Equipment Service provider can at times be lengthy e.g. up to 3 weeks or even longer and could be improved upon.

4	**The uptake of training offered by East Coast Community Healthcare to care home staff in the east is good** Access to training on pressure ulcer prevention for care homes in the Eastern locality is very good. We were told that the East Coast Community Healthcare community nursing teams and assistant tissue viability practitioner offer training in pressure ulcer prevention to care homes in the Great Yarmouth and Waveney area. Results show that care homes take up the offer of training. Training is not offered in any other locality in Norfolk.
5	**Access to other healthcare professionals can be a barrier** to providing the quality of pressure ulcer prevention care that care homes would wish. Some have access to a tissue viability nurse, incontinences nurse specialist, physiotherapist and occupational therapist whilst others do not. Having access to such specialists can be the difference between receiving good quality, accurate advice and support or having to manage without. Some care homes described a very positive relationship with their GP surgery with GPs willing to provide a regular 'surgery' at the care home. A minority said their relationship was poor and that GPs showed little interest in the health of their residents.
6	**Communication between community nurses and care home staff needs to be improved** Repeatedly we were told that care home staff value the community nursing team most highly and that they have a good relationship with the nurses who visit their homes and provide clinical care to their residents. Care homes also told us, however, that at times there are two, different and quite separate care plans in operation when a resident has a pressure ulcer. The community nurses have their care plan, and the care home staff have theirs. For some homes, it was difficult for staff to get meaningful instructions and advice from the community nurses and they felt the care they were giving the resident would improve with better communication with the community nurses.
7	**The use of repositioning or turn charts is common practice** The majority of homes we visited were using repositioning charts or turn charts for their residents who had reduced mobility. Examples of these charts included a specification of the position of the resident, a check of the equipment being used e.g. the setting, fault finding etc, the frequency of repositioning and the requirement for a staff signature.
8	**Some care homes have a 'pressure ulcer champion'** In some care homes, a carer – usually a senior carer – adopts the role of pressure ulcer champion (10 care homes specifically mentioned this role). This role can include a specific responsibility for pressure ulcer care plans, for checking equipment, for sourcing and developing tools e.g. body maps, cascading information and supporting training of other staff.

9	**In West Norfolk experiences of using the Norfolk Health & Community Care Single Point of Access is poor** Some care home staff do not like the "Hub" system of referring a resident for nursing care (this is when a referral is made to the Single Point of Access). In particular, this was a disappointing experience for care homes predominantly in the **western locality**. Triage staff were described as "grumpy", "rude" and "inpatient". It was described as inefficient in that according to several reports sometimes three nurses would attend on the same day to see different residents. Moreover if a nurse happened to be on site and an issue arose with another resident which had not been channelled through the hub the nurse was forbidden to deal with it (although occasionally they would disregard this stricture).
10	**Some care homes described monitoring of wound healing in detail** Some care home staff gave detailed examples of how they monitor and record the progress of a resident's pressure ulcer. Some said they have adopted the practice – having sought the necessary permission from the resident or a family member – of taking photographs of the pressure ulcer as an accurate means to record any changes in the ulcer, to the surrounding tissues, changes in size and so on. One manager told us that they now do this in the care home, as community nurses no longer carry cameras to take photographs of pressure ulcers because they cannot upload the image to their electronic care plans and do not have the means to print them out.
11	**Palliative care and pressure ulcers** Six care homes raised the topic of pressure ulcers in residents requiring palliative care, explaining how care staff will be vigilant and especially alert to warning signs. One care home was part of the Gold Standard for Palliative Care and recently won an award for "Dignity in care".
12	**A paradox of de-skilling care workers alongside increased expectation of 'nursing' of residents** It was commonly reported by care home staff that the responsibility for pressure ulcer care remains with the community nurse but, given the reluctance in many cases for nurses to actually share what they're doing (or at least record anything) some care managers felt excluded and de-skilled, while at the same time occasionally being expected to carry out basic nursing tasks themselves e.g. monitoring specialist pressure ulcer dressings and changing dressing. Residents are being admitted with increasingly complex health needs and frailty and some are admitted very close to end of life, requiring only palliative care. We heard comments to the effect that care workers are doing an increasing amount of nursing; "residential care is now more nursing type care - wish this was recognized". There could be scope for much better collaborative working here.

4. What this means

4.1 Variation in practice

All care homes told us that encouraging mobility and preventing pressure ulcers occurring was an important priority for them: “pressure ulcers are bad for business” and care staff were clear in their intention to maintain their residents’ good health and happiness. From the information gathered we have concluded there is a large variation between care homes in the level of expertise, knowledge of and practice in pressure ulcer prevention and care. As a local Healthwatch, this is of concern to us as it suggests that residents are receiving different kinds of care and a different quality of care, depending on the home and the skills and capacity of the staff within it.

4.2 Equity of access to NHS services

Amongst our findings is a suggestion of inequity of service provision across the county and also inequity of access to specialist healthcare professionals. Equity of access to specialist health care professionals e.g. GPs, community nurses, tissue viability and incontinence specialist nurses, physiotherapists and occupational therapist should not, in theory, be a barrier for care home staff nor their residents. The care home is the *resident’s actual home* and residents should not be *disproportionately disadvantaged* because of the location or nature of their home.

4.3 The need for improved communication on care planning and delivery

It is clear from the responses of care home staff that, if a resident develops a pressure ulcer, there will be two care plans in operation; one created and held by the community nurses and another created and held in the care home’s own care plan for the resident. Care homes staff told us that they want to give the best possible care to their residents but this can be difficult when they do not have access to, or are informed of, any specific instructions in the community nurses care plan. In addition, as much as they desire to do so, it is simply not possible for care home staff to keep family members up to date with any care or treatment delivered to the resident because they themselves are not sufficiently informed. As a local Healthwatch, we can think of few other instances where a next of kin or family member would be denied information about the care provided to a loved one. The general lack of collaborative working and the preciousness of the different professions serve to increase the isolation that many care homes experience. *Communication between community nurses and care home staff regarding the pressure ulcer care plan needs to be improved.*

4.4 The Hub – access to community nursing services in West Norfolk

Care home staff in the west of the county in particular described a range of barriers when using “the hub”. In this locality, the basic model which underpins the Hub whereby the nurse is supporting an individual in his/her home may work sufficiently well in a person’s own home but does not transfer successfully to group living.

4.5 Proposed examples of Good Practice

In carrying out this piece of work, care homes have identified several areas of good practice that they wished to share. These are shown below in Table 15 together a reference to the evidence for including each one.

Table 15

Examples of good practice in pressure ulcer prevention in Norfolk care homes

	Evidence/source	Good Practice
1	Section 3.2.1 Page 17	Training offered by the community nursing service provider (ECCH)
2	Section 3.2.4.1. Figure 11	Use of turn charts and repositioning charts
3	Section 3.2.4.1. Table 7	Variety of repositioning techniques used
4	Section 3.2.3 Page 25	Pressure Ulcer Champions
5	Section 3.2.5 Table 14	Gold Standard in Palliative Care
6	Section 3.2.4.2. Page 18	Photographing the progress and healing of pressure ulcers to improve accuracy of records
7	Section 3.2.2. Page 18	Attention to good nutrition and hydration
8	Section 3.2.4.3. Page 30	Investment in high density foam mattresses for all residents
9	Section 3.2.4.3 Page 34	Undertaking an equipment audit to monitor un-used or broken equipment to ensure a speedy return
10	Section 3.2.4.3 Page 34	Using a checklist to check pressure-relieving equipment is working correctly

4.6 Next steps

We have committed to sharing the findings of this work with the care homes who participated in addition to offering the report to all care homes in the county. Healthwatch Norfolk can continue to engage with the Integrated Community Equipment Service through our representative on the Commissioning Board. It is prudent to revisit this area of work as there are changes ahead to the commissioning and provider landscape e.g. Sustainability and Transformation Plans and on-going budgetary constraints and savings to be made across both the health and social care sectors in the next few years.

The Project Group experienced some difficulty in corresponding with health and social care commissioners and providers during the course of the project in respect of unanswered queries both written and verbal. By summer 2017, Healthwatch Norfolk will

review the frequency of delayed or ignored requests for non-patient identifiable information. This will inform a wider Healthwatch Norfolk Board discussion on how to follow up on recommendations arising from feedback and how to best use our statutory powers in future.

Our findings indicate that further work is required to investigate the numbers of people being discharged from our acute hospitals into community care settings with a pressure ulcer: such matters are the responsibility of our CCGs as commissioners of acute care and we will engage with them to take this work forward. Engaging with providers of domiciliary (home) care will better inform our understanding of pressure ulcers occurring in home care settings. Our recommendations for good practice are feasible in residential care settings but more problematic in a domestic situation where there may be only one carer. Further work is needed in this area to identify a 'good enough' level of pressure ulcer care and awareness when the ideal is probably unrealistic.

5. Recommendations

Table 16

Table of recommendations

Evidence	Recommendation	For	Follow-up Action *"HWN will…*
1.The uptake of the offer of pressure ulcer training provided to care homes by East Coast Community Healthcare is good but there isn't a similar offer to care homes in other localities	To consider including a pressure ulcer training offer to care home staff as part of service specifications and propose the best means to do this for the North, Norwich, West and South localities	Lead CCG Commissioner for Community Nursing Services and Care Homes Lead NCC Commissioner for Care Homes	In January 2018, ask Lead Commissioners to report on any changes to service provider contracts which extend an offer of pressure ulcer training to care home providers.
2. Care home staff don't have access to pressure ulcer care plans held by community nurses, are not consistently informed of the care given to their residents or of specific instructions to enable optimum pressure ulcer care	To consider how to improve communication on pressure ulcer care - and care plans - with care home staff and propose the best means to do this	Norfolk Community Health & Care Trust and East Coast Community Healthcare	In July 2017, contact the 45 care homes again asking them to rate any perceived improvement in communication regarding pressure ulcer care planning.
3. Care homes in the West Norfolk locality were dissatisfied with the level of service provided by the SPoA/"Hub"	To consider how the service offered by the SPoA in the west locality could be improved	Norfolk Community Health & Care Trust	In July 2017, contact care homes in the west locality again asking them to rate any perceived improvement in the service provided by the SPoA.

6. References

Gillespie, B.M et al (2014) *Repositioning for pressure ulcer prevention in adults (Review)* Cochrane Database Systematic Reviews. 2014 Apr 3;(4)

Guy H (2012) *Pressure ulcer risk assessment*. Nursing Times; 108: 4, 16-20

McInnes et al (2015) Cochrane Database Systematic Reviews Apr 13;(4): CD001735

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. (2014) Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Perth; Australia.

Norfolk Community Health & Care Trust (2015) *Preventing Pressure Ulcers - A guide for adults at risk of pressure ulcers*

Appendix 1

Pressure Ulcer Project Group Work Plan (March to October 2016)

Population of interest ***Why?***	* Residents of care homes, frail older people (may have complex health needs, reduced mobility, continence problems, poor nutrition and hydration, poor skin integrity etc.) Link to earlier work in care homes			
Topic ***Why?***	* Pressure ulcer management All the evidence we've gathered to date tells us the quality of pressure ulcer care in vulnerable populations is the most important issue, not equipment *per se*			
Services of interest ***Why?***	*Care homes, pressure ulcer management, community nursing, Integrated Community Equipment Service Care homes without nursing as most pressure-relieving equipment is supplied to care homes, knowledge skills and training in pressure ulcer management, support and interaction with community nursing services, tissue viability nurses, equipment prescribed through the equipment service			
What?	***Where?***	***When?***	***How?***	***Who?***
Look for and identify *'examples of good practice in pressure ulcer management in care homes'*	A sample of care homes across the county, providing beds funded by health or social care Homes providing care for older people, mental illness, physical disability Approx 25 care homes Good spread across the districts	March to June 2016 At times mutually convenient to volunteers and care home managers	Intro Letter to care home Meetings with Care Home Manager Semi-structured interviews a) Informal discussions on prevention and care of pressure ulcers *If the above not successful, or if concerns identified then* b) Enter & View visits conducted to care homes of concern	Pressure Ulcer Project Group members Terry & Margaret in West Norfolk Sam in South & North Norfolk Jennifer in Norwich Carol & Mary in Broadland & East
Output	• Notes from informal discussions • Sifted to identify examples of good practice (similar to method used in dementia car homes project)			
Outcome	• Recommendations for improvements (for care homes / community nurses/ equipment service etc.) • Opportunity to follow up and link with earlier work on dementia care in care homes			

Appendix 2

Good practice in pressure ulcer management – discussion guide

Training

- Does your induction training include pressure ulcer management?
- Is pressure ulcer management training (and/or updates) included in your mandatory training schedule – and if so, what is included and when (how often)?

Assessment

- How do your staff assess skin integrity?
- What assessment tools are your staff using?
- Who is assessing the person with a pressure ulcer or deemed to be at risk of developing a pressure ulcer?
- What happens if a member of staff identifies a pressure ulcer?

Care Planning

- Who is responsible for developing a pressure ulcer Care Plan?
- How is the Care Plan monitored and reviewed?
- Who monitors and reviews the Care Plan?
- If you make a referral to community services, how long do you have to wait for a response?
- When services respond, what will they do?
- Are community nurses involved in care planning?

Repositioning

- Do your staff specify the repositioning of the resident within the Care Plan?
- How is the resident repositioned?
- How often, and by whom? Is this recorded in the residents Care Plan?

Monitoring and review

- Who is responsible for monitoring the resident and the pressure ulcer?
- How often is this done?
- Who is responsible for reviewing the Care Plan?

Equipment

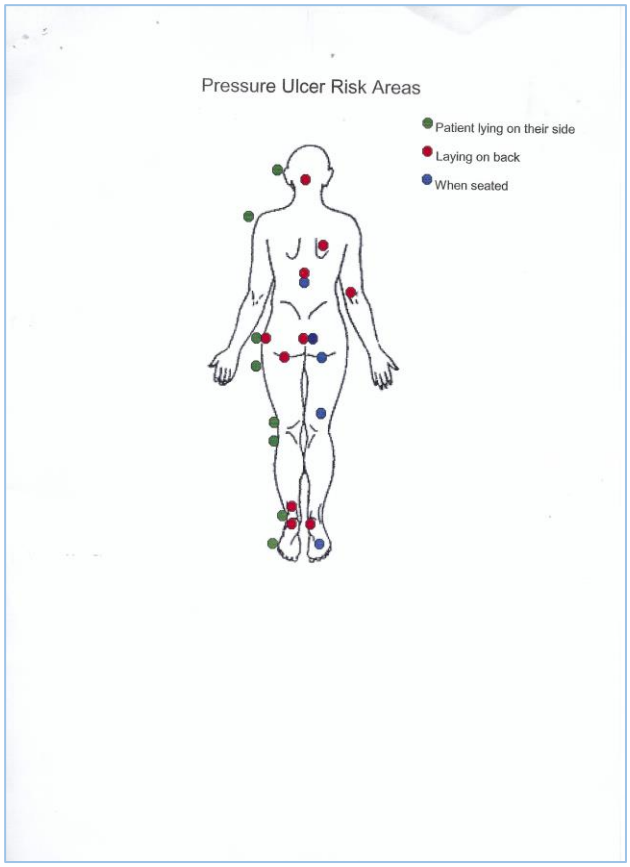
- If a resident needs equipment, who decides what equipment would be most effective?
- Who orders the equipment for the resident?
- How long do you usually wait for equipment?
- What instructions do your staff receive on using the equipment correctly?

Good practice

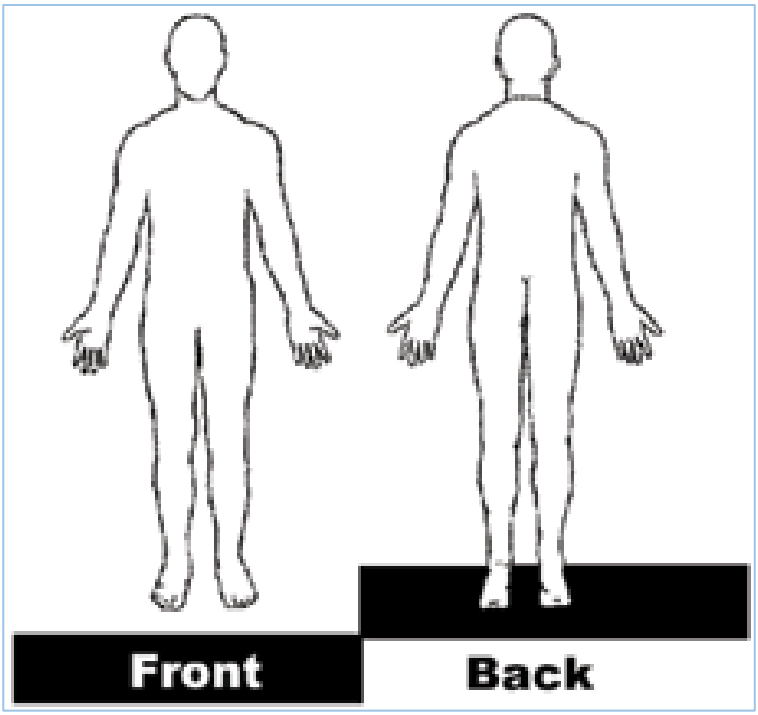
- Is there anything you would like to mention as an example of good practice; something you are really proud of?

Appendix 3. Examples of assessment tools shared by care homes

Pressure risk areas



Body map



RUNWOOD HOMES

QF 145

WATERLOW PRESSURE ULCER ASSESSMENT

A	
BUILD	**SCORE**
Average (BMI 20-24.9)	0
Above Average (BMI 25-29.9)	1
Obese (BMI > 30)	2
Below Average (BMI < 20)	3

B	
SKIN TYPE	**SCORE**
Healthy	0
Tissue Paper	1
Dry	1
Odedematous	1
Clammy	1
Discolored	2
Broken Spot	3

C	
SEX / AGE	**SCORE**
Male	1
Female	2
14-49	1
50-64	2
65-74	3
75-80	4
81 +	5

D	
CONTINENCE	**SCORE**
Fully Continent / Catheterised	0
Urine Incontinence	1
Faecal Incontinence	2
Urinary and Faecal Incontinence	3

E	
MOBILITY	**SCORE**
Fully	0
Restless	1
Apathetic	2
Restricted	3
Inert	4
Chair Bound	5

Special Risk Factors

F	
MALNUTRITION SCREENING TOOL	
A. Has person lost weight recently? YES - Go to B NO - Go to C UNSURE - Go to C and Score 2	**B.** Weight loss score 0.5 - 5kg =1 5 - 10kg=2 10 - 15kg=3 >15kg=4 unsure =2
C. Patient eating poorly or lack of appetite 'NO' = 0 'YES' SCORE = 1	NUTRITION SCORE If > 2 refer for nutrition assessment / intervention

G	
MEDICATION	**SCORE**
Steroids	4
Cytotoxics	4
High Dosage	4
Anti Inflammatory	4

H	
TISSUE MALNUTRITION	**SCORE**
Cachexia	8
Multiple Organ Failure	8
Single organ failure (cardiac, respiratory)	5
Peripheral Vascular Disease	5
Anemia	2
Smoking	1

I	
NEUROLOGICAL DISEASE	**SCORE**
Diabetes/MS/CVA Paraplegia	4 -- 6
Motor Sensory	4 -- 6
Paraplegia (Max 4-6)	4 -- 6

SCORE		TOTAL
10+	AT RISK	
15+	HIGH RISK	
20+	VERY HIGH RISK	

J	
MAJOR SURGERY /TRAUMA	**SCORE**
Below waist spinal	5

At Risk:
1. Care Plan to be written
2. 2-4 hourly turns unless fully mobile

High Risk:
1. Care Plan to be written
2. 2-4 hourly turns unless fully mobile
3. Air Mattress for high risk to be in place.

Very High Risk:
1. Care Plan to be written
2. 2-4 hourly turns unless fully mobile
3. Replacement mattress to be in place and cushions required if setting in a chair.

SIGNATURE:	DESIGNATION:	DATE:

RUNWOOD HOMES

QF 145

MONTHLY WATERLOW SCORE

Name:		Date of Birth:	

Date	A	B	C	D	E	F	G	H	I	J	Score	Sign

Appendix 4. Example of a turning/repositioning chart

TURN CHART

Name: _____

Date: _____

Turn: ---------- hourly ----------

Time	Position	Comments	Signed
01.00			
02.00			
03.00			
04.00			
05.00			
06.00			
07.00			
08.00			
09.00			
10.00			
11.00			
12.00			
14.00			
15.00			
16.00			
17.00			
18.00			
19.00			
20.00			
21.00			
22.00			
23.00			
24.00			

Appendix 5. Example of a pressure relieving equipment checklist

Pressure equipment daily checksheet

BLACK SWAN Care Group

Month

Resident name	Room number	Equipment present			Setting details	Date checked (Initial)																										
		Mattress	Cushion	Other		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

etting details should include setting number/ weight or N/A if not electrical
ate checked should be initialled to confirm all pressure equipment applicable to the resident has been checked and is present, set correctly and operational