Sussex Community NHS
NHS Trust

Person at risk of SCALE

Skin Changes at Life's End

- **For patients with advanced disease of progressive life limiting conditions- Ask the question - Would you be surprised if the patient were to die in the next few months, weeks or days? Is the patient on the GSF register, have a DNA CPR or receiving the DS1500 benefit? Does the patient have deteriorating health, with limited reversibility, (needs help with personal care, in bed or chair for more than 50% or more of the day) and have persistent troublesome symptoms despite optimal treatment of underlying condition(s).**
- **Complete comprehensive patient assessment ⇨ S= Subjective skin and wound assessment ⇨ O= Objective observation of skin and wound.**
- **Physical examination of skin identifying and documenting skin changes associated with the end of life or other aetiologies including any existing pressure ulcers.**

Determine and Document Aetiology

- **A= Assess and document aetiology**.
- **P= Plan of care**

Consider the 5 P's, the patients and circle of care wishes. Discuss goal setting in end of life care.

Patient Centred Concerns

- Pressure relieving checklist, Patient Choice agreement completed and documented. Review date recorded
- Consider triggers of concern relating to non-concordance policy or self-neglect Consider mental capacity
- Does Safeguarding Adult policy apply?
- Consent form completed

5 Ps

Prevention

(Refer to Patient centred Concerns)

- Appropriate care plans in place and signed by professional and patient/carer
- Complete Purpose T, risk assessment and refer to flow chart and toolkit, this should be used in conjunction with professional judgement. Plan review date and document actions
- Complete MUST, Manual handling, Falls, Pain tool and Continence assessment
- Review frequency of visits and identify relevant triggers for patient/carers to call for help
- Self-care elements assessed and documented
- Consider advice from colleagues and refer to other professionals as appropriate

Prescription

(Treatable)

Carefully consider whether full healing of a pressure sore is a reasonable goal

Ensure Prevention guidelines are followed

- Wound assessment- complete weekly
- Wound care plan
- Manage, odour, bleeding and exudate
- Interventions aimed at addressing pain, quality of life
- TVN referral/ liaison if required
- Complete incident report if required in line with Trust policy
- Re-visit issues preventing improvement

Preservation

(Maintenance)

Ensure prescription guidelines are followed

- Review mobility and equipment provision
- Review care plan for the carers
- Communicate realistic goals with family and document

Consider:

- Patient preferences and comfort
- Psychological factors
- Body image
- Sleep patterns
- Socialisation

Palliative

(Care and Comfort)

Ensure Preservation guidelines are followed

- Discuss as part of an MDT and family and record
- Documentation of deterioration and pertinent patient risk factors
- Identify and manage patient risk factors including pain assessment
- Assess procedural and non-procedural pain, review pain relief

Review:

- Dressing selection to reduce discomfort when changed and manage odour and exudate
- Patient positioning and Manual handling in line with patient

Preference

(Patient desires)

Ensure Palliative guideline are followed

- Patient centred care
- Patient preference and comfort
- Careful documentation

Implement - Evaluate – Educate all stakeholders, including the patient and their circle of care.

- **I= Implement appropriate plan of care. Plan of care must be matched with healthcare resources along with appropriate education and feedback from the patient's circle of care as consistent with the patient's goals and wishes.**
- **E=Evaluate and educate all stakeholders. Inter-professional team to facilitate education, management and periodic evaluation of the care plan as the patient's health status changes**

Evaluate & revise care plan as needed

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Kelly Saunter VERSION 7- 13/4/15