Poor nutrition and fluid intake =

- Dehydration, Low energy and dizziness
- Poor wound healing
- Increased risk of infection
- Change in bowel habits

THINGS TO CONSIDER

- Could you offer high calorie snacks, fortified meals, flavoured water, fortified milkshakes and food little and often? For support and recipes see

https://www.enhertsccg.nhs.uk/nutrition-and-blood

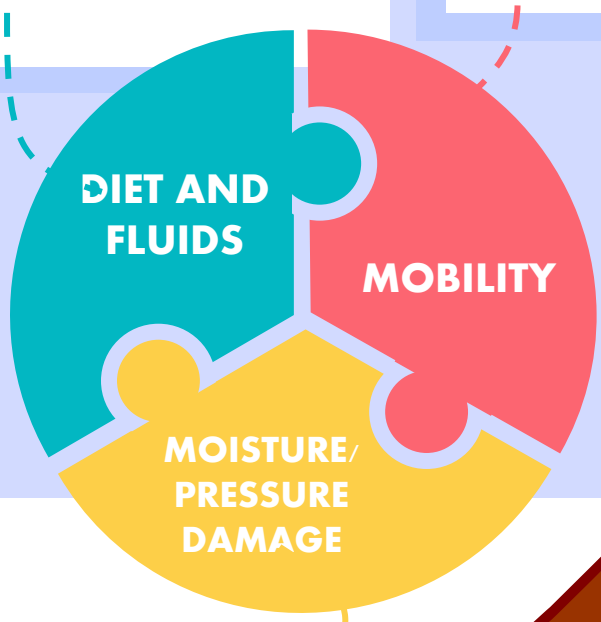
- Can you increase intake of nutritious foods such as meat, fish, eggs, milk, cheese and nuts plus fruit and vegetables to promote wound healing. It is recommended that all residents take a Vitamin D supplement.
- Should the resident have a nutrition care plan including increased weight monitoring with MUST and food/fluid/bowel charts in place?
- Do your diabetic residents have good blood glucose control?

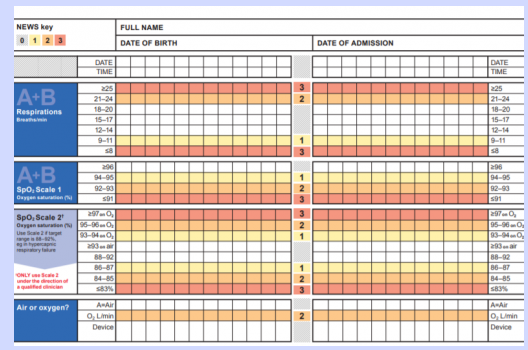
Reduced or loss of mobility =

- Isolation
- Low mood
- Risk of falls
- Increased risk of pressure /moisture skin damage

THINGS TO CONSIDER

- Has the residents condition changed; do they need different management /support? E.g. turn chart.
- Is their equipment still appropriate and in good working order? Is it serviced?
- Can you encourage the resident and enlist friends and family to set gradual goals to exercise, stretch and practice relaxation?
- Can a member of staff attend the HCPA chair-based exercise training?





Poor skin care, incontinence, pressure damage=

- Increased risk of infection
- Skin breakdown
- Low mood
- Increased level of care needed

THINGS TO CONSIDER

- Have you completed a continence assessment? Or does this need to be reassessed?
- What else is happening with the resident? Has a change in one of their care needs meant that they are now at increased risk of moisture and/or pressure ulcer skin damage? E.g. if highly vulnerable skin and immobile has the resident got any preventive barrier creams prescribed (only protects from moisture)? Have you completed a body map?
- Have you completed a wound assessment/skin inspection?
- Have their vital signs been checked to also see if there any signs of infection?
- Have you completed a pain assessment? Are they in pain majority of time, on movement, or when skin is touched? Do they need their analgesia reviewing?
- Have you updated all their care plans to reflect these assessments being carried out, their current needs and has this been handed over to all staff?

HOLISTIC PATIENT ASSESSMENT

- WOUND BED ASSESSMENT USING TIME
- DIAGNOSIS AND DIFFERENTIAL DIAGNOSIS
- SETTING OF OBJECTIVES WITH THE PATIENT
- AGREE TO A TREATMENT PLAN/CARE PLAN FOR SOCIAL ACTIVITIES
- REVIEW OF CARE PLAN AND WOUND

Please note, this poster is to support thinking about the bigger picture for your residents.
Please still follow referral pathways to specialist services as needed.

CONNECTING CARE