NHS
Birmingham Community Healthcare
NHS Foundation Trust

Think.....

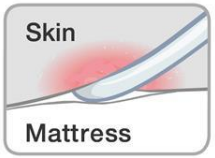
SSKIN

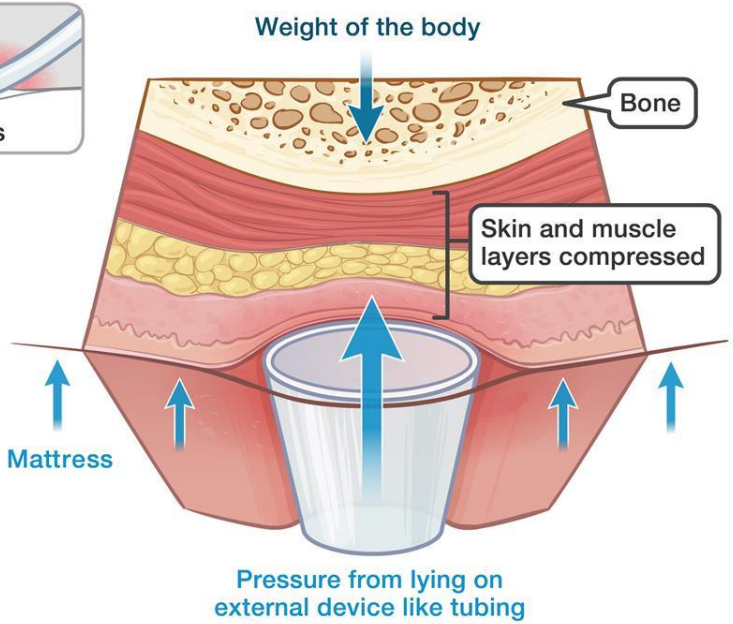
PRESSURE ULCER PREVENTION

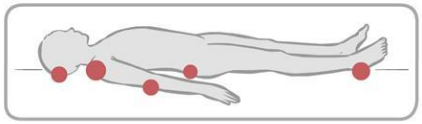
Definition

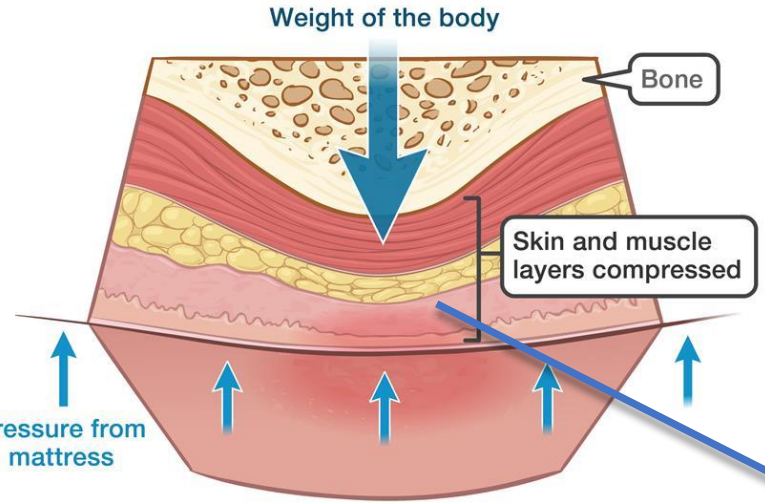
- A **Pressure Ulcer** is localized damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful
- They account for the most common type of harm in most Trust organisations
- Despite extensive prevention programmes, evidence suggests about 1,700 to 2,000 patients a month develop pressure ulcers in England
- Pressure damage costs the NHS more than £3.8 million every day

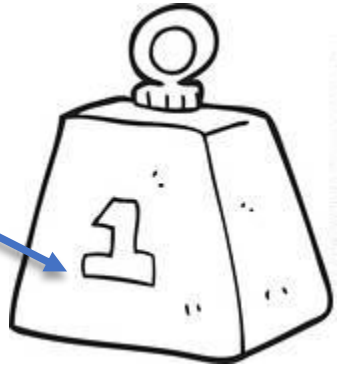
CAUSES







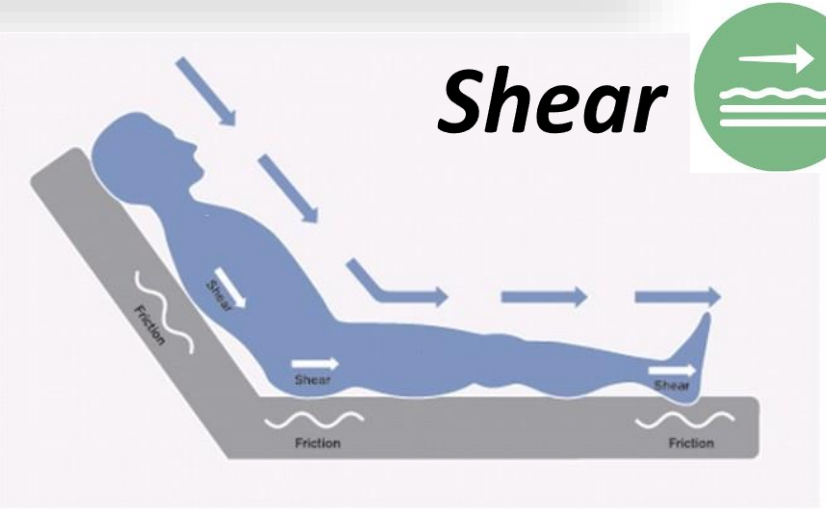




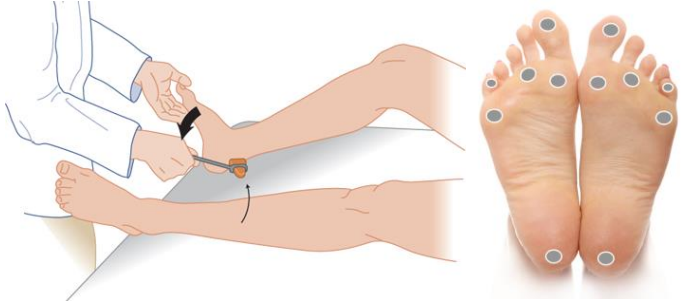
Sustained pressure

Shear force or a force created when the skin of a patient stays in one place as the deep fascia and skeletal muscle slide down with gravity. This can also cause the pinching off of blood vessels which may lead to ischemia and tissue necrosis. Bedridden patients and wheelchair users in half-sitting position are very vulnerable for shear wounds.

CAUSES



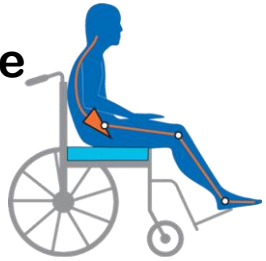
Pressure Ulcer Risk Factors



Poor sensation

Devices such as tubing and splints

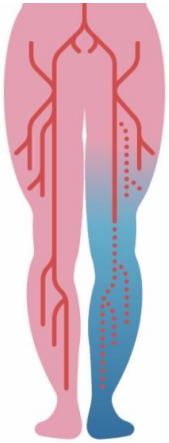
Poor posture



Skin changes with ageing process

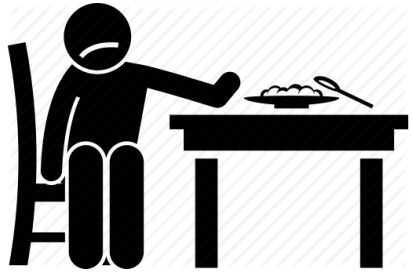
Contractures

Poor circulation



Chronic diseases

Incontinence



Poor nutrition and hydration

Birmingham Community Healthcare NHS
NHS Trust

Patient name: Rita Orehere
NHS no: 1097654321

Adapted Walsall Score Pressure Ulcer Risk Asssessment Calculator

Risk Categories (See Category Guidance Sheet for more detail)		Date	9.6.16						
		Time	09:30						
			Score	Score	Score	Score	Score	Score	Score
Awareness	No deficit		(0)	0	0	0	0	0	0
	Deficit		3	3	3	3	3	3	3
Mobility	Walks independently		0	0	0	0	0	0	0
	Walks with the assistance of an aid		3	3	3	3	3	3	3
	Unable to walk or dependent on care		(8)	8	8	8	8	8	8
Skin condition or bony prominences	Healthy		(0)	0	0	0	0	0	0
	Skin changes		2	2	2	2	2	2	2
	Significant skin changes or pressure ulcer		4 High Risk	4 High Risk	4 High Risk	4 High Risk	4 High Risk	4 High Risk	4 High Risk
Nutritional Status	No dietary issues		0	0	0	0	0	0	0
	Dietary issues		(4)	4	4	4	4	4	4
Bladder Incontinence	None		0	0	0	0	0	0	0
	Occasional		(1)	1	1	1	1	1	1
	Frequent		4	4	4	4	4	4	4
Bowel Incontinence	None		(0)	0	0	0	0	0	0
	Occasional		4	4	4	4	4	4	4
	Frequent		6	6	6	6	6	6	6
Carer Input	No carer		0	0	0	0	0	0	0
	Active carer		0	0	0	0	0	0	0
	Intermittent carer		(2)	2	2	2	2	2	2
Total Score (State number)	0 - 3 (No risk)								
	4 - 9 (Low risk)								
	10 - 14 (Medium risk)								
	15 or above (High risk)		15						
Or any significant skin change or pressure ulcer (High risk) ✓									
Name:			Shelton Gore						
Signature:			[signature]						
Designation:			SIN						

Adapted Waterlow risk assessment tool

Complete the form in full. If Hb unknown on initial assessment, ensure a Full Blood Count has been requested.

Look at the identified risks and ensure a plan of care is in place to minimise the risk of developing a pressure ulcer.

Consider other risk factors including previous pressure ulcers and heavy oedematous limbs as risk factors for developing a pressure ulcer.

Predictors of risk		Waterlow risk assessment **weeks 5 / 6 / 7 / 8**				
10 + at risk · 15 + high risk · 20 + very high risk		Date	15.3.16			
Amber and red shaded areas should be used as triggers for increased risk.		Time (24hr clock)	15:00			
		Write score - do not tick	Score	Score	Score	Score
Build / weight for height	Average, BMI 20-24.9	0				
	Above Average BMI 25-29.9	1				
	Obese BMI > 30	2				
	Below average BMI < 20	3	3			
Skin Inspection (pressure areas only)	Healthy	0				
	Tissue Paper	1	1			
	Dry	1	1			
	Oedematous	1	1			
	Clammy, pyrexia	1				
	Discoloured	2				
	Broken / spot	3				
Sex / age	Male	1				
	Female	2	2			
	14-49	1				
	50-64	2				
	65-74	3				
	75-80	4	4			
	81+	5				
Appetite	Average	0				
	Poor	1				
	Nasogastric tube / fluids only	2	2			
	Nil by Mouth / anorexia	3				
Continence	Complete / catheterised	0				
	Urinary incontinence	1				
	Faecal incontinence	2	2			
	Urinary and faecal incontinence	3				
Mobility	Fully	0				
	Restless / fidgety	1				
	Apathetic	2				
	Restricted	3	3			
	Bed bound	4				
	Chair bound	5				
Tissue malnutrition	Terminal cachexia	8				
	Multiple organ failure	8				
	Single organ failure (respiratory, renal, cardiac)	4				
	Peripheral vascular disease	5	5			
	Anaemia (Hb <8)	2	2			
	Smoking	1				
Neurological deficit	Diabetes / MS / CVA / motor sensory / paraplegia	4-6 (6 maximum)	4			
Medication	Cytotoxics, long term / high dose steroids, anti inflammator	4 maximum				
Total score (Add up the score column record the total)			30			
Name of assessor (please print name)			JUSTIN CASE			
Signature of assessor (please sign name)			JCase			

May score more than once in this section

Discoloured = C1 PU or DTI
Broken = C2, C3 , unstageable or C4 PU

Ongoing NG/PEG fed = 0

Check patient notes to ascertain co-morbidities

Use clinical judgement to ascertain severity of Diabetes or Stroke e.g. stable Diabetes on diet may score 4, whereas unstable Diabetes on Insulin may score 6

NHS
Midlands and East

Surface:
Make sure your patients have the right support.

Skin Inspection:
Early inspection means early detection. Show patients and carers what to look for.

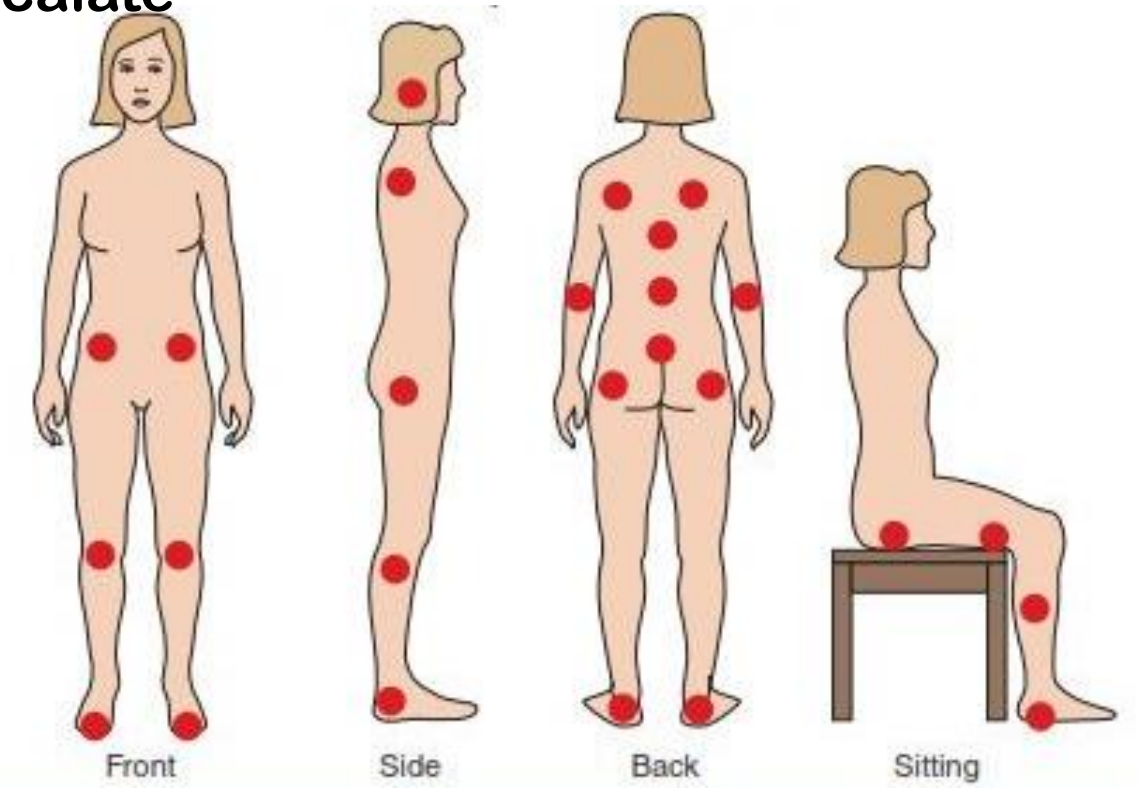
Keep your patients moving.

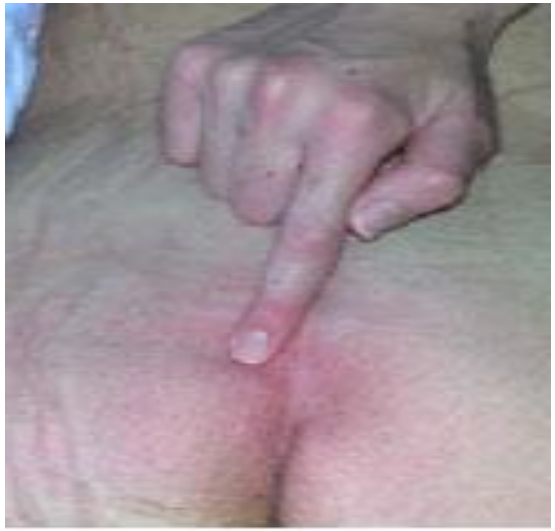
Incontinence/ Moisture:
Your patients need to be clean and dry.

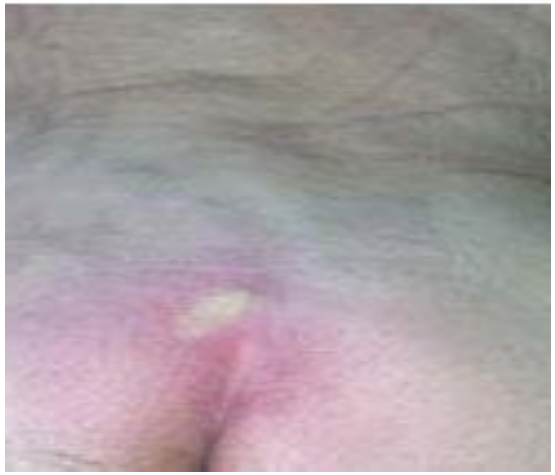
Nutrition/ Hydration:
Help patients have the right diet and plenty of fluids.

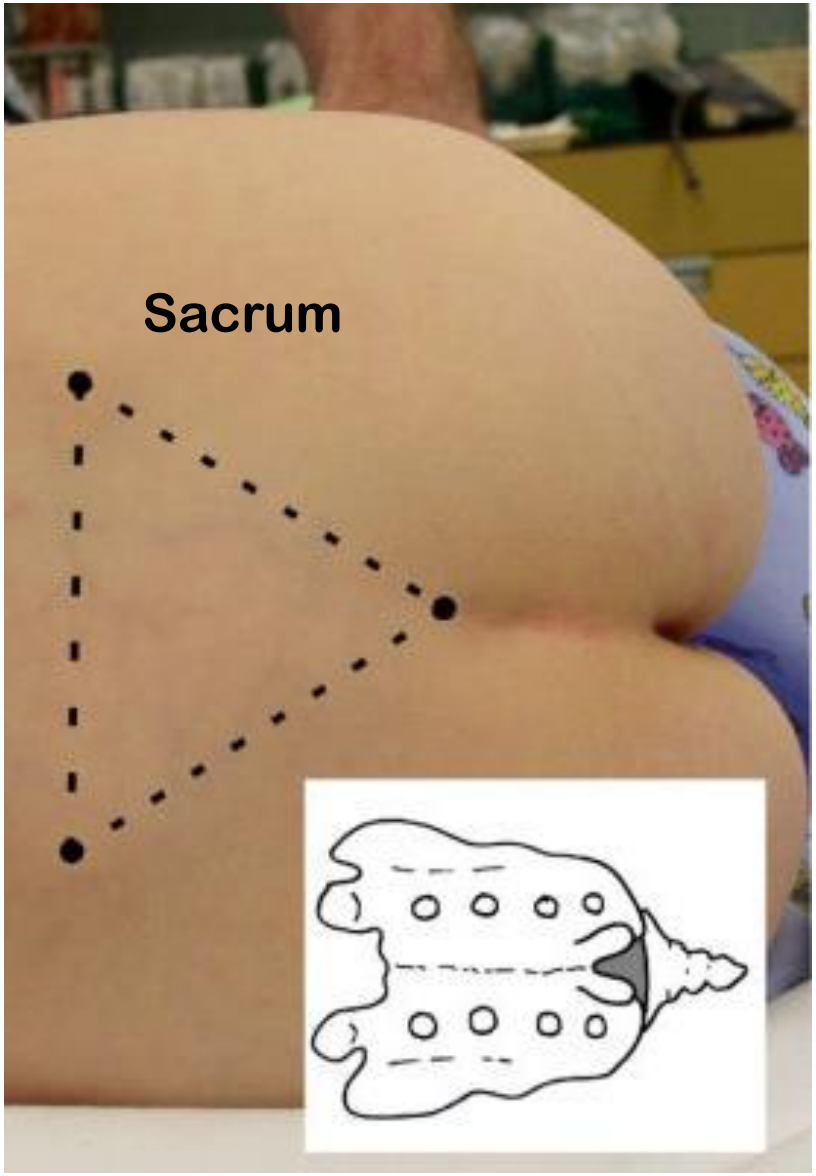
SKIN INSPECTION

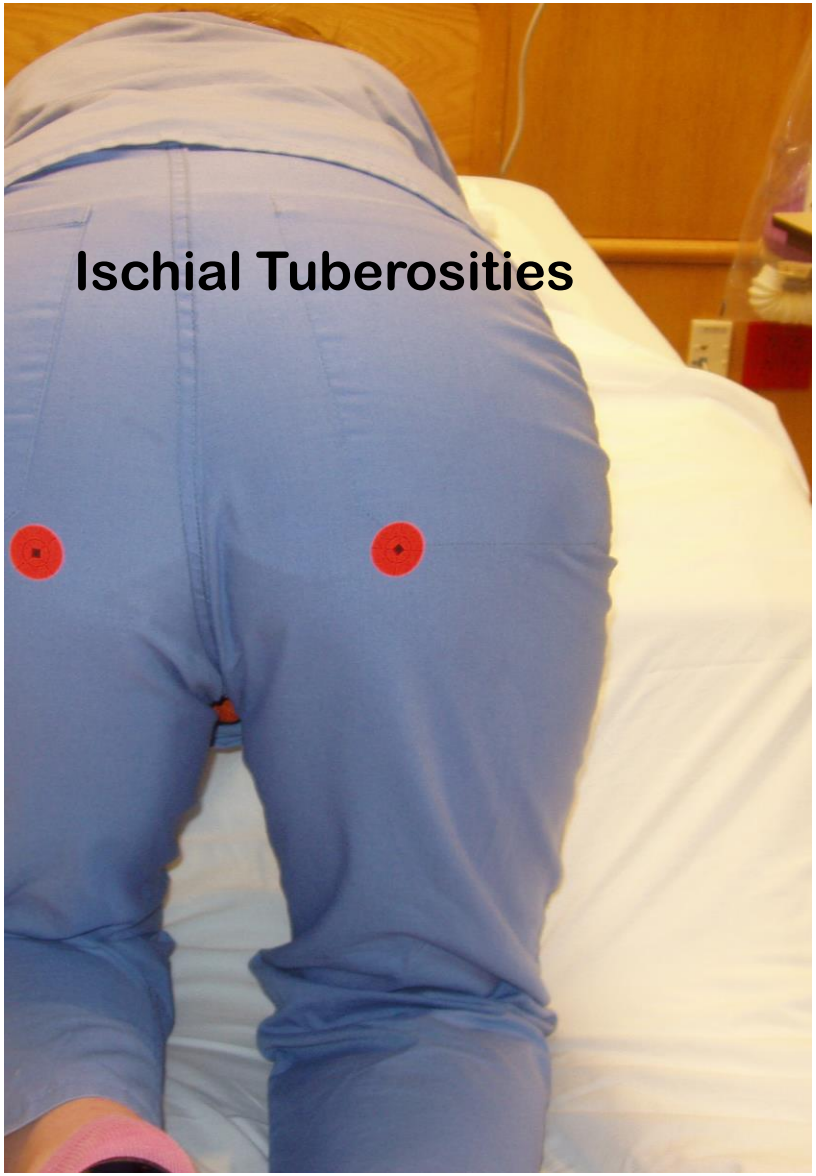
Pressure ulcers often occur over bony areas, like in the picture below. Look out for the signs of pressure damage, document & escalate





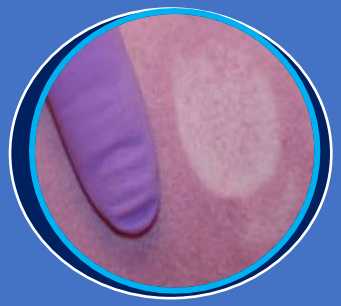



Sacrum


Ischial Tuberosities

Signs & Symptoms of Pressure Ulcers

NB Present over a bony prominence (where the bone is immediately below the skin surface) or under a device



Persistent Blanching Redness

Non-Blanching Redness =

Category 1 Pressure Ulcer

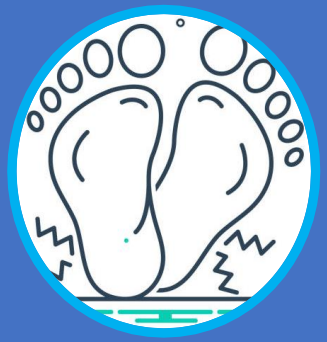
Discoloured Skin

Painful

Sore

Signs & Symptoms of Pressure Ulcers

NB Present over a bony prominence (where the bone is immediately below the skin surface) or under a device



Numbness

Deep itch

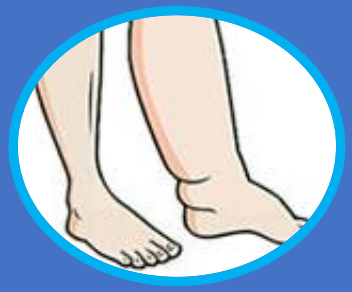
Warmer or Cooler Skin

Skin feels Soft, Spongy, Boggy

Signs & Symptoms of Pressure Ulcers

NB Present over a bony prominence (where the bone is immediately below the skin surface) or under a device

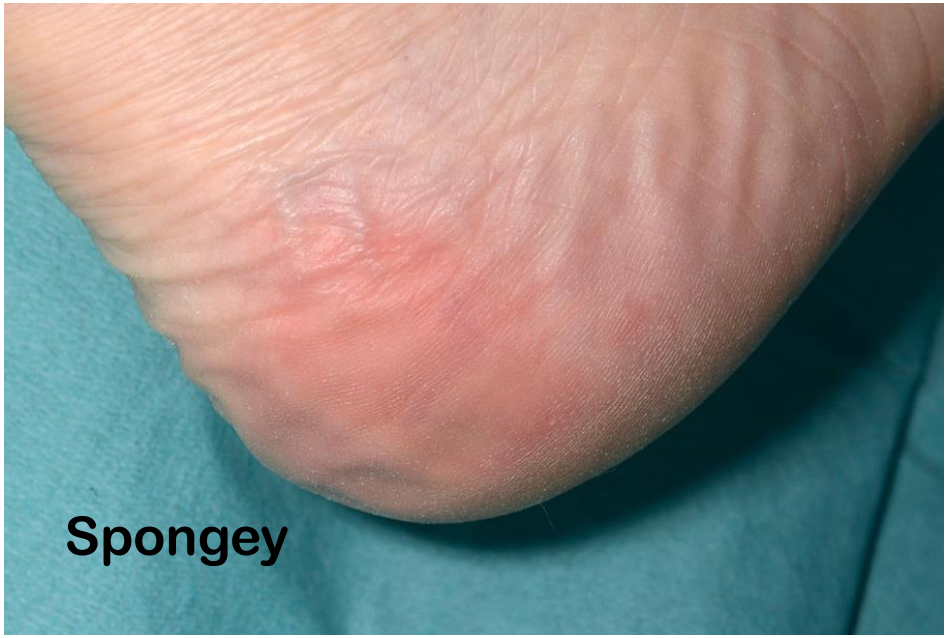
Hardened Skin

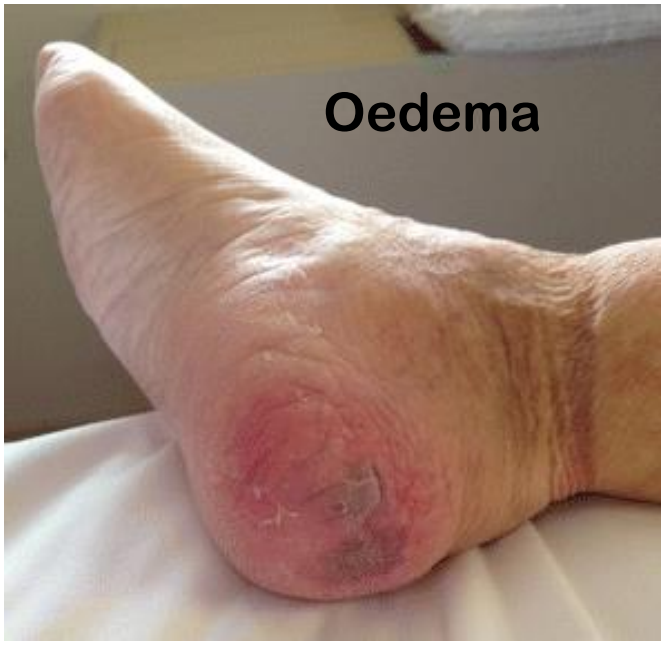


Swelling (Oedema)

Broken Skin

Ulcers





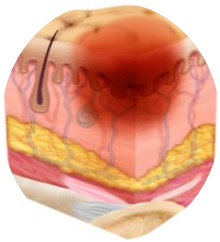
Examples

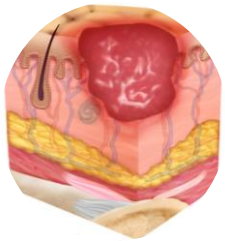
Skin Inspection Chart

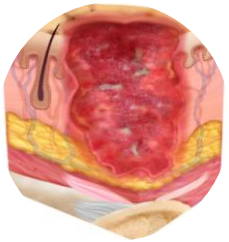
Left ear	✓	✓	✓	✓	✓	✓	✓
Right ear	✓	✓	✓	✓	✓	✓	✓
Left shoulder	✓	✓	✓	✓	✓	✓	✓
Right shoulder	✓	✓	✓	✓	✓	✓	✓
Left elbow	✓	✓	✓	✓	✓	✓	✓
Right elbow	✓	✓	✓	✓	✓	✓	✓
Spine	✓	✓	✓	✓	✓	✓	✓
Left hip	✓	✓	✓	✓	✓	✓	✓
Right hip	✓	✓	✓	✓	✓	✓	✓
Left ischium	✓	✓	✓	✓	✓	✓	✓
Right ischium	✓	✓	✓	✓	✓	✓	✓
Sacrum	✓	✓	✓	✓	✓	✓	✓
Left buttock	✓	✓	✓	✓	✓	✓	✓
Right buttock	✓	✓	✓	✓	✓	✓	✓
Left knee	✓	✓	✓	✓	✓	✓	✓
Right knee	✓	✓	✓	✓	✓	✓	✓
Left ankle	✓	✓	✓	✓	✓	✓	✓
Right ankle	✓	✓	✓	✓	✓	✓	✓
Left heel	RB	RB	RB	Purple	RNB	Purple	DTI
Right heel	✓	✓	✓	RB	RB	RB	RNB
Other:							

EPUAP Pressure Ulcer Classification

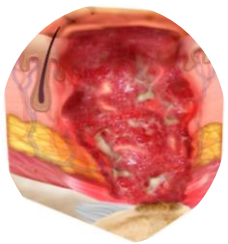
Category 1	Category 2	Category 3
		
Non-blanching erythema of INTACT skin	Partial-thickness skin loss with <u>exposed dermis</u> *(not through)*	Full thickness skin loss *(extends to fat layer)*
No Datix required	Complete Datix	Complete Datix & escalate as SI if BCHC acquired
No TVN referral required	No TVN referral required	Must be referred to TVN

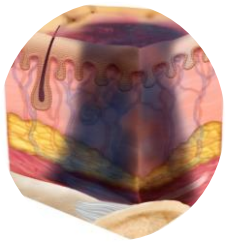


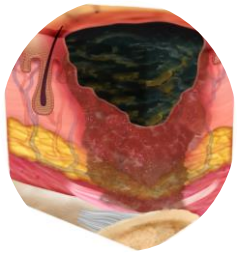




Category 4	DTI	Unstageable
		
Full thickness loss of skin & tissue *(extends to fascia & muscle)*	Persistent non-blanchable deep red, maroon, purple discoloration *(may also look like blood-filled blister)*	Obscured *(with necrosis of slough)* full-thickness skin & tissue loss
Complete Datix & escalate as SI if BCHC acquired	Complete Datix	Complete Datix
Must be referred to TVN	No TVN referral required, but must be monitored at least weekly by registered nurse	Must be referred to TVN but must be monitored at least weekly by registered nurse







Medical Device Related Pressure Ulcer

Pressure ulcers that result from the use of devices designed & applied for diagnostic or therapeutic purposes *(e.g. catheter, NG, splints, O_2 tubing).*
(The pressure ulcer often conforms to the pattern or shape of the device)

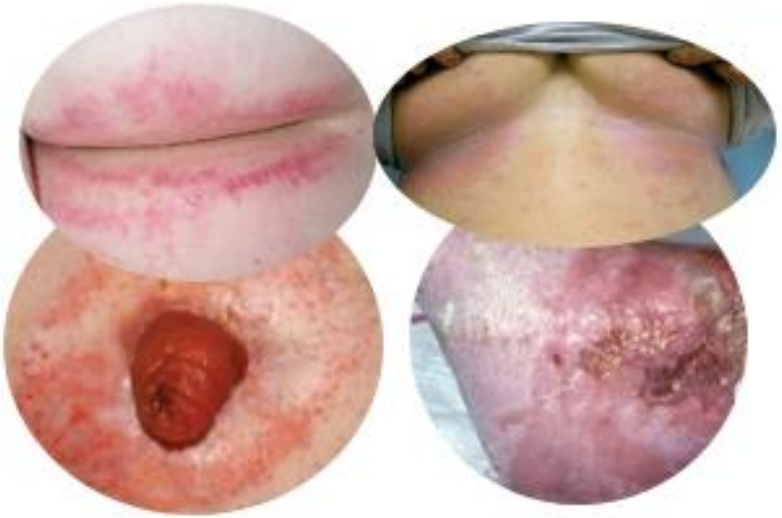
Complete drop-down box on Datix to indicate category of pressure damage & **(d)** device related

Refer to TVN if Category 3, 4 or unstageable

If a PU evolves / deteriorates & becomes another category – re-Datix

MASD

Moisture Associated Skin Damage



Inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, exudate, saliva, or mucus

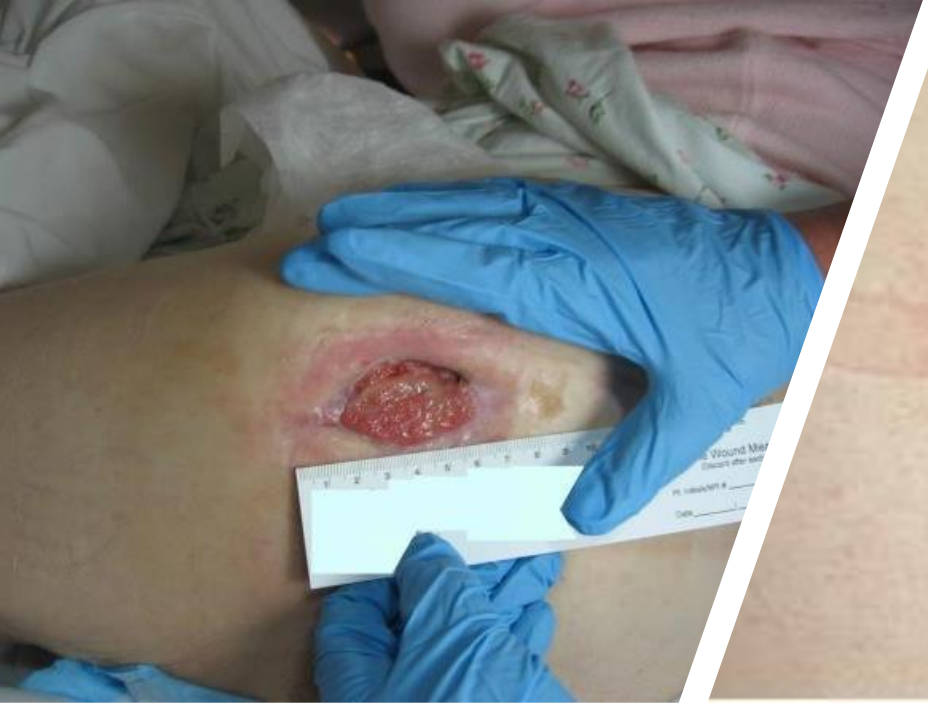
Complete Datix for MASD

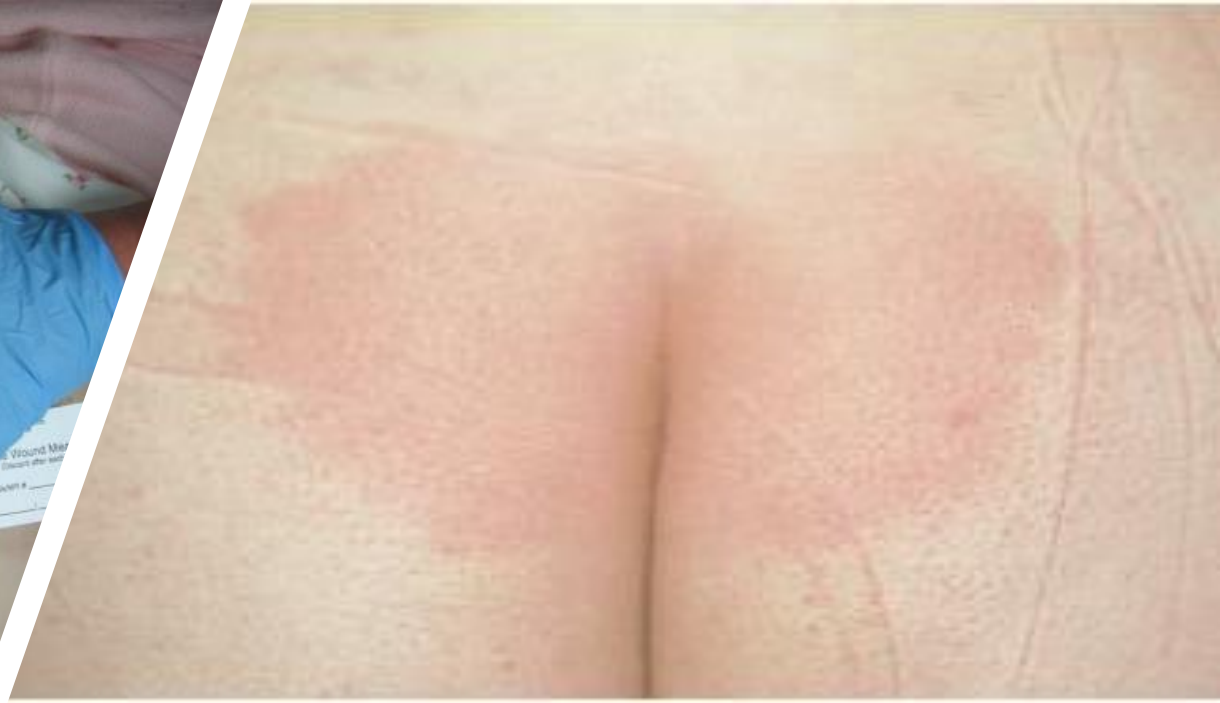
Combined lesion – Datix as a PU

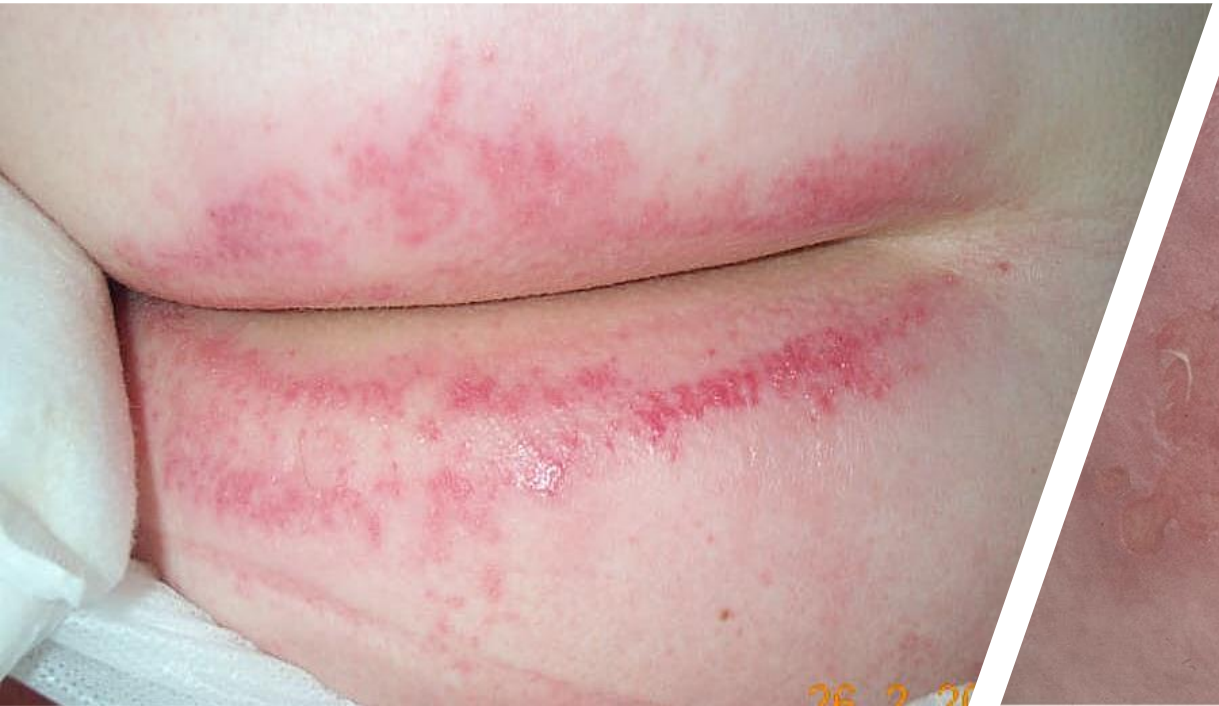
No TVN referral required

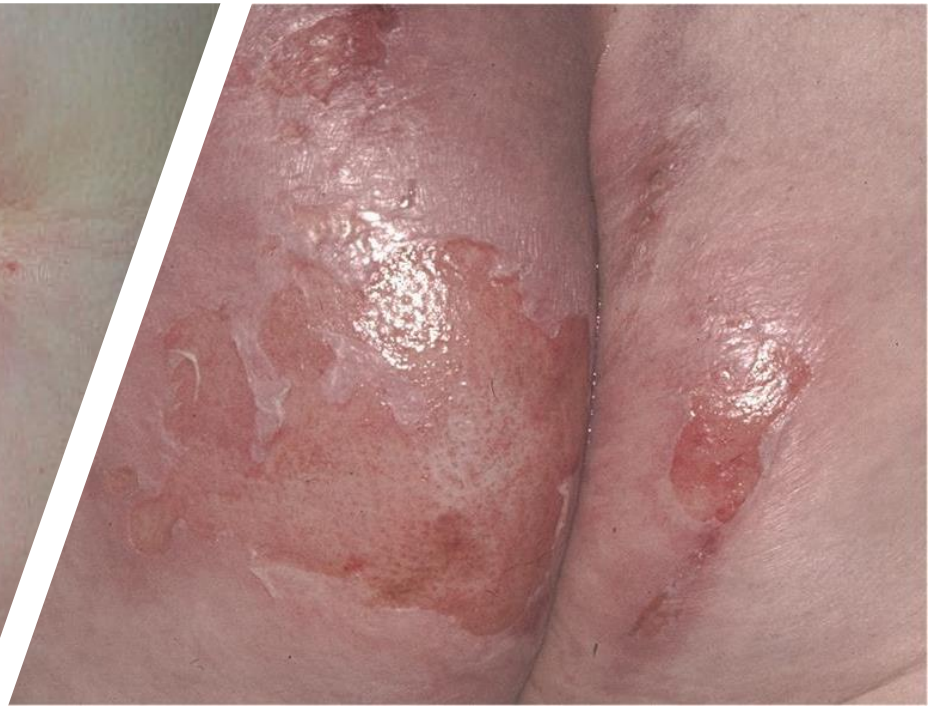
IAD exclusion = under 4 years

Is it Incontinence Associated Dermatitis (IAD) or a Pressure Ulcer?	
Incontinence Associated Dermatitis	**Pressure Ulcer**
Shiny, wet skin from moisture	History of prolonged exposure to pressure
Non-uniform blanching redness	Usually circular non-blanching redness / halo-effect
Located in natal cleft, gluteal folds, perineum, posterior/inner thighs, near anus but not over a bony prominence. May develop mirror-image lesion either side of anus	Located over a bony prominence or from a medical device e.g. catheter tubing
Pink & macerated areas	May become necrotic due to ischaemia
Superficial eroded areas & spots	Can be superficial or deep. Often single lesion
Diffuse & irregular edges	Defined edges & often circular

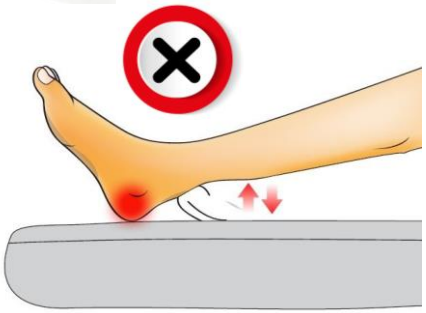






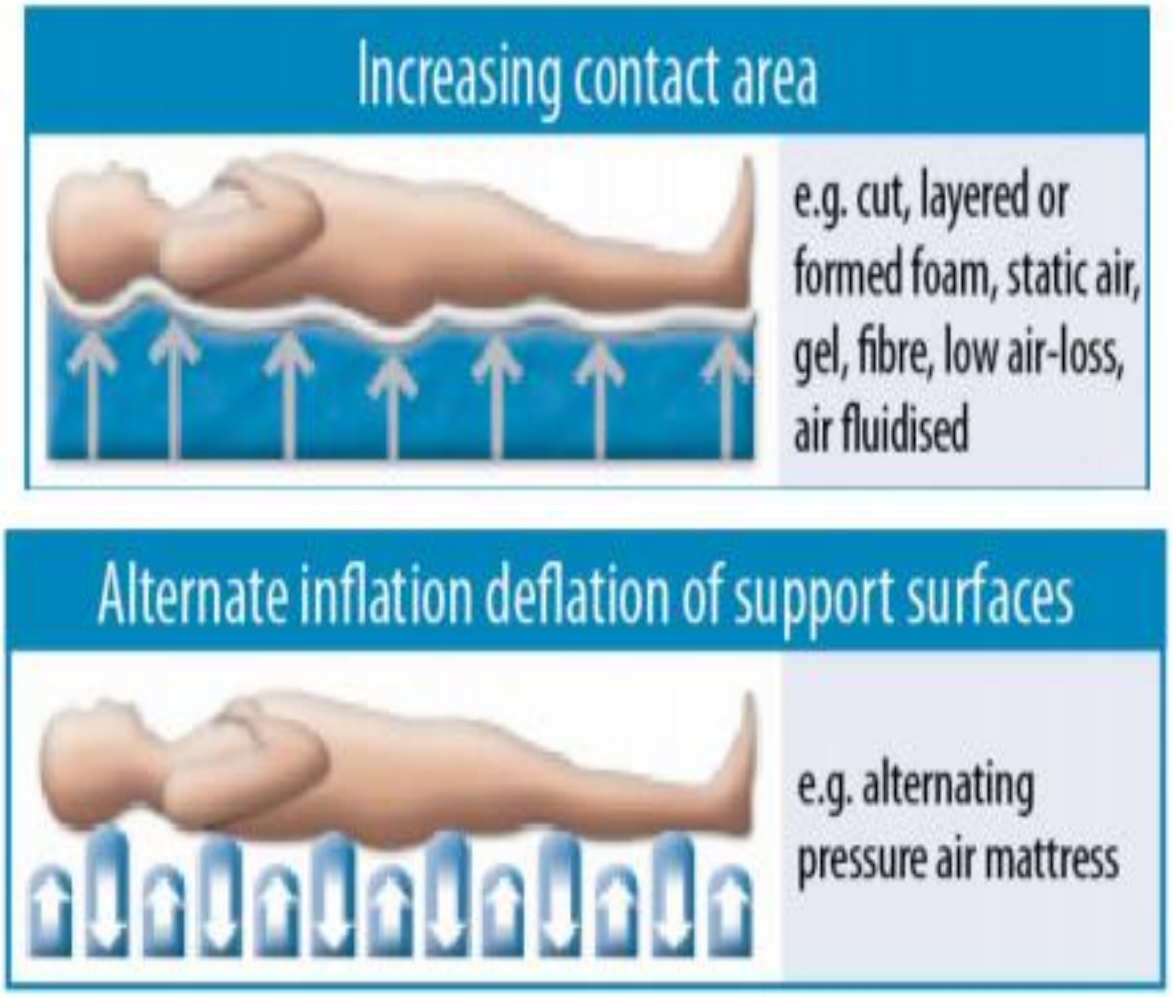


SURFACE - EQUIPMENT



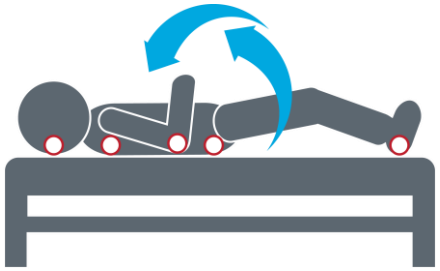
Ensure the patient has suitable Pressure Redistributing Equipment for 24/7 care

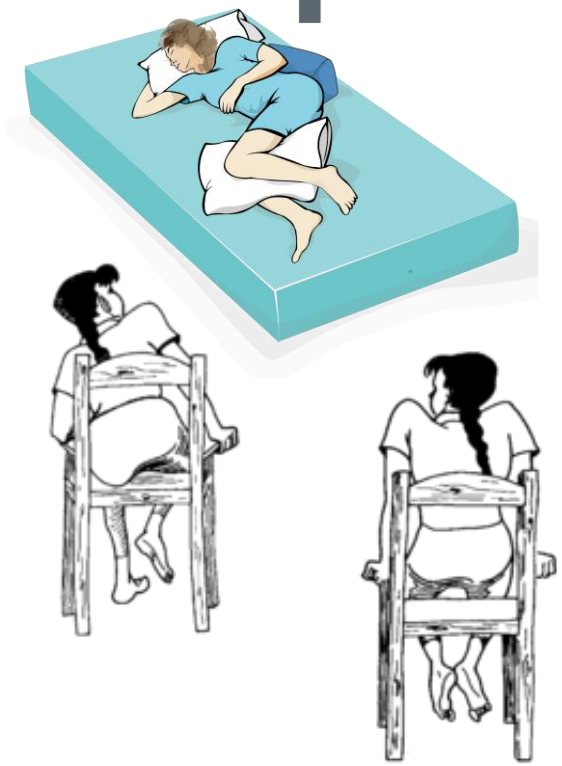
How pressure redistributing support surfaces are designed to work

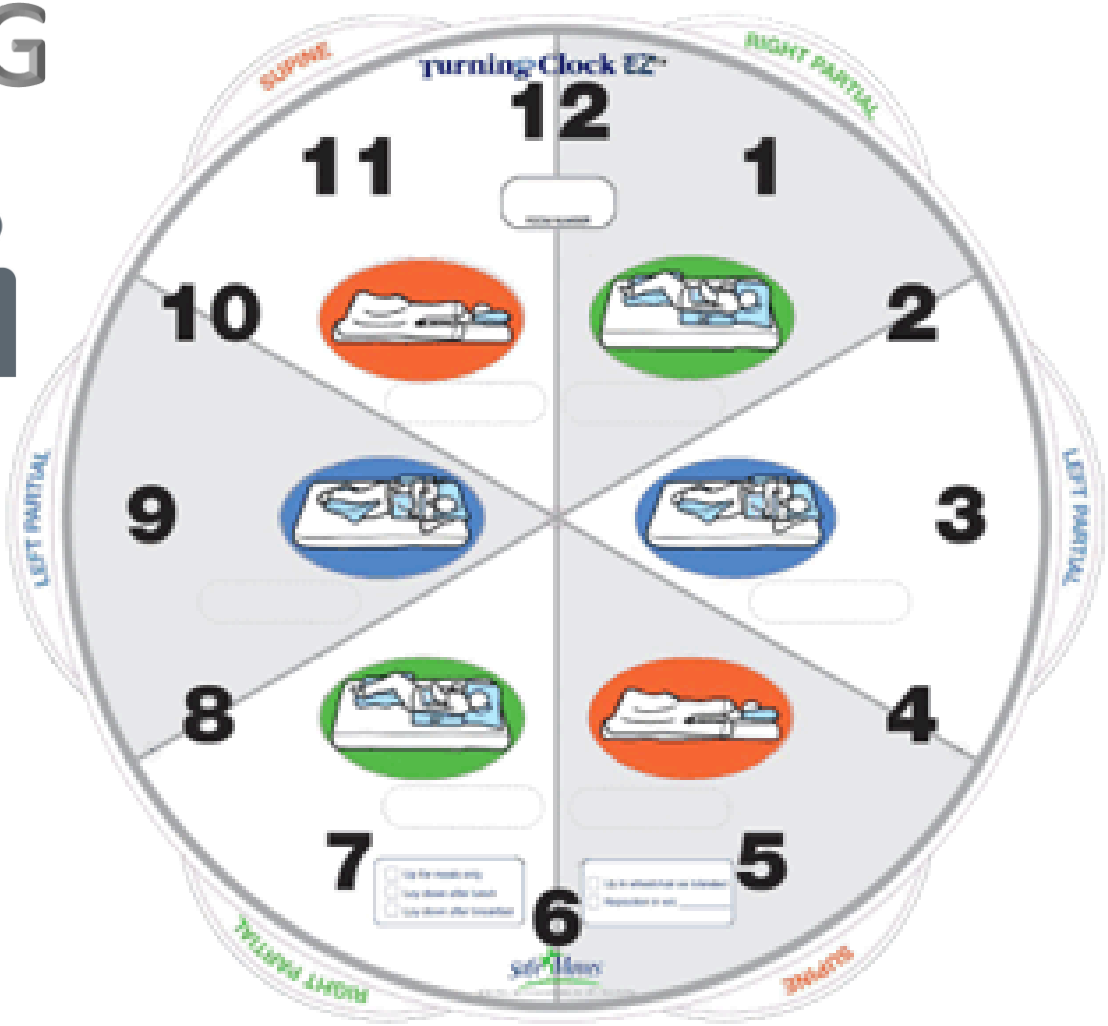


'Pressure redistributing support surfaces are designed to either ***increase the body surface area*** *that comes in contact with the support surface (to reduce interface pressure) or to sequentially* ***alter the parts of the body that bear load****, thus reducing the duration of loading at any given anatomical site'*

KEEP MOVING







Reposition regularly to relieve pressure. Every 2 – 4 hours is often recommended, less if sitting out. Use a slide sheet to reduce shear & friction. Consider the 30^0 tilt. Document that you have moved the patient on the repositioning schedule

Repositioning record

Planned frequency of movement..... Every 3 hours .....

BCHC staff to complete this chart following all repositioning and movement, utilising the codes below.

Position codes:

RS ..... Right side
LS..... Left side
B ..... Back
SO..... Sitting out
ST..... Standing
RT ..... 30 degree tilt to right
LT..... 30 degree tilt to left
ST..... Standing
R ..... Refused

Activity codes:

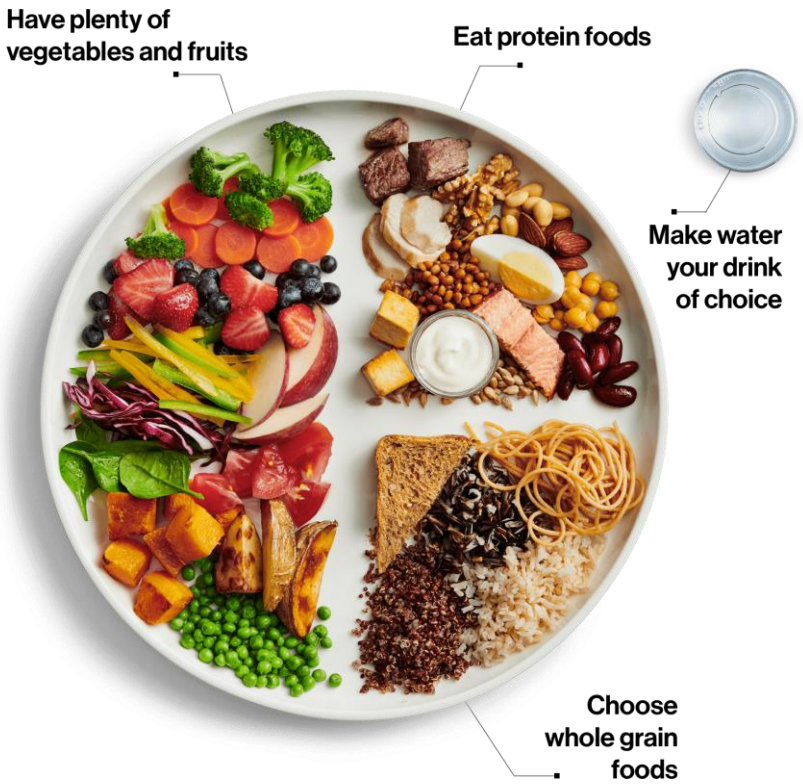
H..... Hoisted
T..... Toileted
RO..... Rolled
O..... Other (please specify)

Date	Time	Position code	Activity code	Comment	Name	Signature
10/2/16	10:00	SO	H/ST	Standing Hoist used	Stan Dirty	S Dirty
10/2/16	13:30	SO	T	Used Commode	Stan Dirty	S Dirty
10/2/16	17:00	SO	T	Used Commode	Stan Dirty	S Dirty
10/2/16	20:30	RS	H	Back to bed	Ivor Walker	I Walker
11/2/16	00:30	LS	RO	Slide sheet to move	Ivor Walker	I Walker
11/2/16	03:30	RS	RO	"	Ivor Walker	I Walker
11/2/16	06:30	B	RO	Set up	Ivor Walker	I Walker
11/2/16	10:30	SO	H	Bed-chair	Lettie Turner	L Turner
11/2/16	13:00	ST	T	Sitting out	Lettie Turner	L Turner
11/2/16	16:30	ST	T	Sitting out	Lettie Turner	L Turner
11/2/16	19:00	ST	T	Sitting out	Lettie Turner	L Turner
11/2/16	21:00	RS	H	Back to bed	Ivor Walker	I Walker

INCONTINENCE

Continence assessment is required. Find out cause. Encourage visiting the toilet every 1 – 2 hours. pH Cleanser, an appropriate Skin Barrier & Containment products are essential. Monitor & report back on effectiveness of regime

NUTRITION & HYDRATION



Undertake a MUST screening assessment. If you are unable to weigh, consider a mid upper arm circumference (MUAC). Check if fluid intake is adequate. Have they lost any weight before admission? Where intake is sub-optimal, use food diaries, fluid intake monitoring charts & red jug & tray. Consider fortified supplements & snacks if nutritional intake is poor. If the patient has lost weight document & escalate

Pressure ulcer prevention care plan

Assessment to be completed by a registered Healthcare Professional for all patients on admission or if clinical condition has changed.
Care plan should be reviewed monthly, 2 monthly or 3 monthly in line with risk assessment.

	Assessment Plan and rationale (please explain rationale in bullet points)		
What is the Walsall score?	15 – High Risk. Patient is able to stand on her own but she cannot walk. Some incontinence NB Poor appetite – food booster leaflet given & explained		
Mattress selection Refer to equipment algorithm	Repose mattress (Carers shown how to check + inflate. Advised to check Twice weekly as minimum.)		
Seating/ cushion selection	Repose cushion. (Carers shown as above) Patient + carers await to contact Community Nurse if any problems with equipment		
Other equipment e.g. Repose Foot Protectors	Dermal pads to elbows To check elbows to ensure no skin damage from brace – demonstrated action to carers.		
Repositioning regime Frequency of movement, suitable positions/time in each position	Advised to stand every hour & move from side to side every 15 mins. Advised to return to bed in afternoon & carers shown how to undertake 30° Tilt.		
Advice and referrals	Think SSKIN booklet given to patient / carers	Yes (Yes)	No
	Referral to TV team	Yes	No (No)
	Referral to dietician	Yes	No (No)
Skin inspection	Completed and recorded	Yes (Yes)	No
For patients with pressure ulcers	Wound assessment / treatment plan completed	Yes	No
	Patient and family informed	Yes	
Care agency	Is a care agency involved? If so, name: Bravocare visiting 3x daily.		
	Are they aware of care plan?	Yes	No
Name	Ivor Sore		
Signature	Ivor Sore.		
Date	10.1.16		

	Review (if variance from assessment, report to trained nurse)		
Month 1	Variance?	Yes	No (No)
	Think SSKIN reinforced	Yes (Yes)	No
	Signature: Unseen Boy		
	Date: 24.1.16		
Month 2	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 3	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 4	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 5	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 6	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 7	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 8	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 9	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 10	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 11	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		
Month 12	Variance?	Yes	No
	Think SSKIN reinforced	Yes	No
	Signature:		
	Date:		