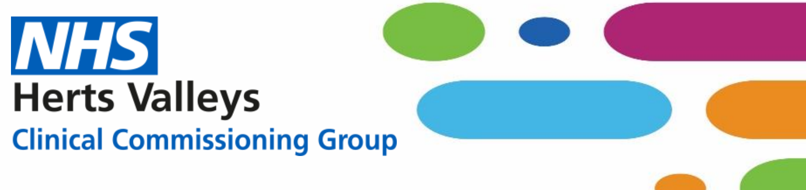


Pressure ulcer prevention for care homes

Care Home Improvement Team (CHIT)

NHS Herts Valleys CCG

Pressure Ulcer Prevention for Care Homes

- **Aim of the session**

- For staff to understand:

- What is Pressure Ulcer (PU)
- SSKIN assessment tool
- Moisture lesion

- To enable all staff to:
- monitor the wellbeing of residents and identify early signs of deterioration
- know how to communicate their concerns to their colleagues and outside agencies
- understand the roles of the different health services available to their residents
- understand the importance of documenting changes in residents' wellbeing and how to describe their concerns

What is a pressure ulcer?

A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence.

What causes a pressure ulcer?

It can be caused by the weight of the body bearing down on a localised area of the skin and underlying tissue.

It can also be caused by shear. That's when part of the body tries to move but the surface of the skin remains fixed.

4 main factors are implicated in pressure ulcer development:

- **Interface pressure**
- **Shear**
- **Friction**
- **Moisture**

Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

Pressure ulcers most commonly develop in individuals who are not moving about, for example bedridden or confined to a wheelchair.

How do you ensure that your resident's receive the right care to prevent pressure damage?

SSKIN Bundles
A five step care plan

Surface

SSKIN

Surface: Make sure your patients have the right support.

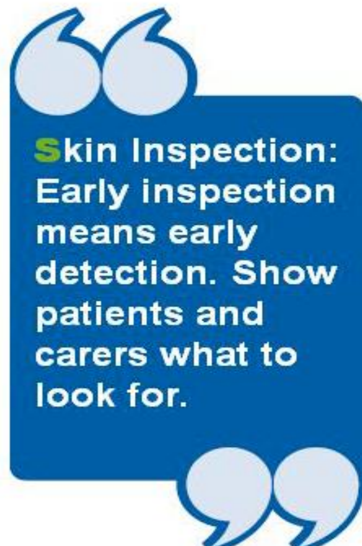
Surfaces

- When a person is lying or sitting, pressure is exerted through the skin onto soft tissue
- The amount of pressure is related to the patients weight and the size of the contact area between the patient and the surface
- Using the correct support surface is key to preventing and managing pressure ulcers
- Monitor and manage your residents weight – (healthy diet/MUST)
- Keep care plans up to date and plan for both good days and bad days

Surfaces

- Narrow seat wheelchair/chair
- Seated posture
- Contractures
- Spasm
- Incorrect cushion
- Pressure mapping
- Reassess your residents requirement daily
- Understand how to use equipment and do not exceed the weight limit
- Ensure required checks and maintenance are undertaken on the equipment to make sure it is functioning correctly

Skin Inspection

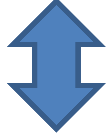


Skin Inspection

Early Warning signs of skin damage

Stop

Look



Listen

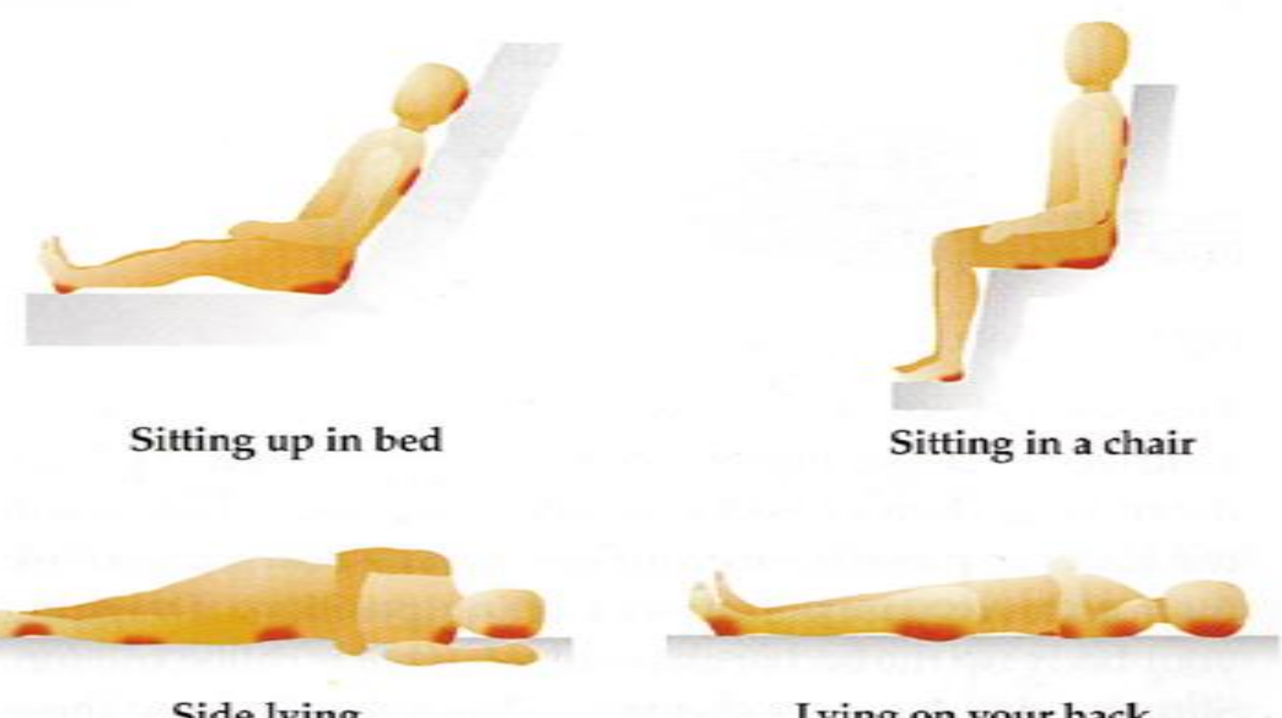
Recognise

Respond

Escalate

Document

Areas of risk



Assessment aids

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

BUILD/WEIGHT FOR HEIGHT	♦	SKIN TYPE VISUAL RISK AREAS	♦	SEX AGE	♦
AVERAGE BMI = 20-24.9	0	HEALTHY	0	MALE	1
ABOVE AVERAGE BMI = 25-29.9	1	TISSUE PAPER	1	FEMALE	2
OBESE BMI > 30	2	DRY	1	14 - 49	1
BELOW AVERAGE BMI < 20	3	OEDEMATOUS	1	50 - 64	2
BMI=Wt(Kg)/Ht (m)²		CLAMMY, PYREXIA	1	65 - 74	3
		DISCOLOURED GRADE 1	2	75 - 80	4
		BROKEN/SPOTS GRADE 2-4	3	81 +	5

MALNUTRITION SCREENING TOOL (MST)
(Nutrition Vol.15, No.6 1999 - Australia)

A - HAS PATIENT LOST WEIGHT RECENTLY		B - WEIGHT LOSS SCORE	
YES	- GO TO B	0.5 - 5kg	= 1
NO	- GO TO C	5 - 10kg	= 2
UNSURE	- GO TO C AND SCORE 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

CONTINENCE	♦	MOBILITY	♦
COMPLETE/ CATHETERISED	0	FULLY	0
URINE INCONT.	1	RESTLESS/FIDGETY	1
FAECAL INCONT.	2	APATHETIC	2
URINARY + FAECAL INCONTINENCE	3	RESTRICTED	3
		BEDBOUND e.g. TRACTION	4
		CHAIRBOUND e.g. WHEELCHAIR	5

SCORE

- 10+ AT RISK
- 15+ HIGH RISK
- 20+ VERY HIGH RISK

SPECIAL RISKS

TISSUE MALNUTRITION	♦	NEUROLOGICAL DEFICIT	♦
TERMINAL CACHEXIA	8	DIABETES, MS, CVA	4-6
MULTIPLE ORGAN FAILURE	8	MOTOR/SENSORY	4-6
SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC,)	5	PARAPLEGIA (MAX OF 6)	4-6
PERIPHERAL VASCULAR DISEASE	5	**MAJOR SURGERY or TRAUMA**	
ANAEMIA (Hb < 8)	2	ORTHOPAEDIC/SPINAL	5
SMOKING	1	ON TABLE > 2 HR#	5
		ON TABLE > 6 HR#	8

MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4

Scores can be discounted after 48 hours provided patient is recovering normally

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Obtainable from the Nook, Stoke Road, Henlade TAUNTON TA3 5LX
* The 2005 revision incorporates the research undertaken by Queensland Health
www.judy-waterlow.co.uk

Skin health

- Keeping skin healthy is important for pressure ulcer prevention
- Once skin breaks down, it is at even higher risk for further damage
- As people age, the skin changes, making it more vulnerable to damage, it may be dry, paper-thin and itchy
- A reddened area, or on darker skin, areas that are darker than usual may indicate a breakdown is about to happen

Early warning indicators

- Reddened areas of skin on light skinned people
- Blue/purple patches on dark skinned people
- Blisters
- Hot/cool areas
- Swelling
- Patches of hard skin

Keep your residents moving

SSKIN

Keep your patients moving.

Keep your residents moving

- Pressure ulcers can develop very quickly for patients that are unable to move
- The best way to reduce pressure is regular movement and changing of position regularly to relieve and redistribute pressure
- Sitting time should be no longer than 2 hours at any one time
- Use repositioning charts for at-risk residents
- Checking your skin every day for early signs and symptoms of pressure ulcers
- Healthy, balanced diet that contains enough protein and a good variety of vitamins and minerals

Incontinence

Incontinence

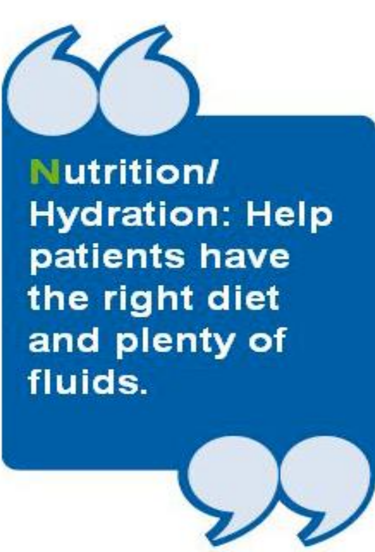
- Use a barrier film or cream to keep fluid away from the skin
- Use correct incontinence products
- Check pads regularly
- Know the difference between a moisture lesion and a pressure ulcer
- Discuss with the District Nurses

Incontinence

Moisture lesion recognition

Pressure ulcer	Moisture lesion
History of immobility, short or long term	History of faecal and/or urinary incontinence
Will be circular and symmetrical in shape	May be associated with sweating in skin folds or natal cleft
May take on a butterfly wing shape if it spans out from sacrum	Irregular and asymmetrical shape
Will be over a bony prominence (unless a piece of equipment is the cause)	Lesions will be over fatty parts of the buttocks and thighs, and are not isolated to being located over the bony prominences
May have necrotic or thick sloughy tissue present	Lesions may extend into perineal area, scrotum and vulva
If associated with an external device causing the pressure the lesion will take the shape of the device	Usually there is no necrotic tissue or slough
Grade according to classification tool	Do not grade

Nutrition



Nutrition

- Support your residents to eat a healthy diet and have regular drinks
- Remember- under nutrition is a common feature in people with dementia
- Use the Malnutrition Universal Screening Tool (MUST) screening tool to identify residents who are at risk Ensure your residents care plan reflects their nutrition plan
- Early signs of risk may include, unexplained weight loss, reduced appetite and poor food intake

What else can you do?

- Does your resident have capacity to understand the risk of pressure ulcer development?– assess (may require best interests)
- Support your residents understanding, consider terms and language, advise of potential impact on health, explain, explore/discuss reasons and action, seek a compromise, involve family & friends, escalate for support/intervention, document all discussions and actions
- Involve patients and family in shared decision making from the beginning
- Discuss the SSKIN care bundles
- Staff engagement - make sure everyone knows how to identify a resident who may be at risk
- Raise awareness

Pressure Ulcer Stages

Stage I	Stage II	Stage III	Stage IV	Suspected Deep Tissue Injury (SDTI)	Unstageable
• Intact skin with localized, non-blanchable erythema over a bony prominence. • The area may be painful, firm or soft and warmer or cooler when compared to surrounding tissue. • Darkly pigmented skin may not show visible blanching, however the colour of the Stage I ulcer will appear different than the colour of surrounding skin. • Indicates the patient is at risk for further tissue damage if pressure is not relieved.	• A partial thickness wound presenting as a shallow, open ulcer with a red/pink wound bed. • May also present as an intact or open/ruptured serum-filled or serosanguinous-filled blister. • Slough may be present but does not obscure the depth of tissue loss.	• A full thickness wound. • Subcutaneous tissue may be visible but bone, tendon and muscle are not exposed. • May include undermining or sinus tracks. • Slough or eschar may be present but does not obscure the depth of tissue loss.	• A full thickness wound with exposed bone, tendon or muscle. • Often includes undermining and/or sinus tracks. • Slough or eschar may be present on some parts of the wound bed but does not obscure the depth of tissue loss.	• A localized purple or maroon area of intact skin or a blood-filled blister that occurs when underlying soft tissue is damaged from friction or shear. • May start as an area that is painful, firm or mushy/ boggy, and warmer or cooler than the surrounding tissue but can deteriorate into a thin blister over a dark wound bed or a wound covered in thin eschar. • Deterioration may be rapid, exposing additional layers of tissue even with optimal treatment, and may be difficult to detect in individuals with dark skin tones.	• A wound in which the wou bed is covered by sufficien slough and/or eschar to preclude staging.

Approved Training Provider

Moisture Lesion

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Moistur e Lesion

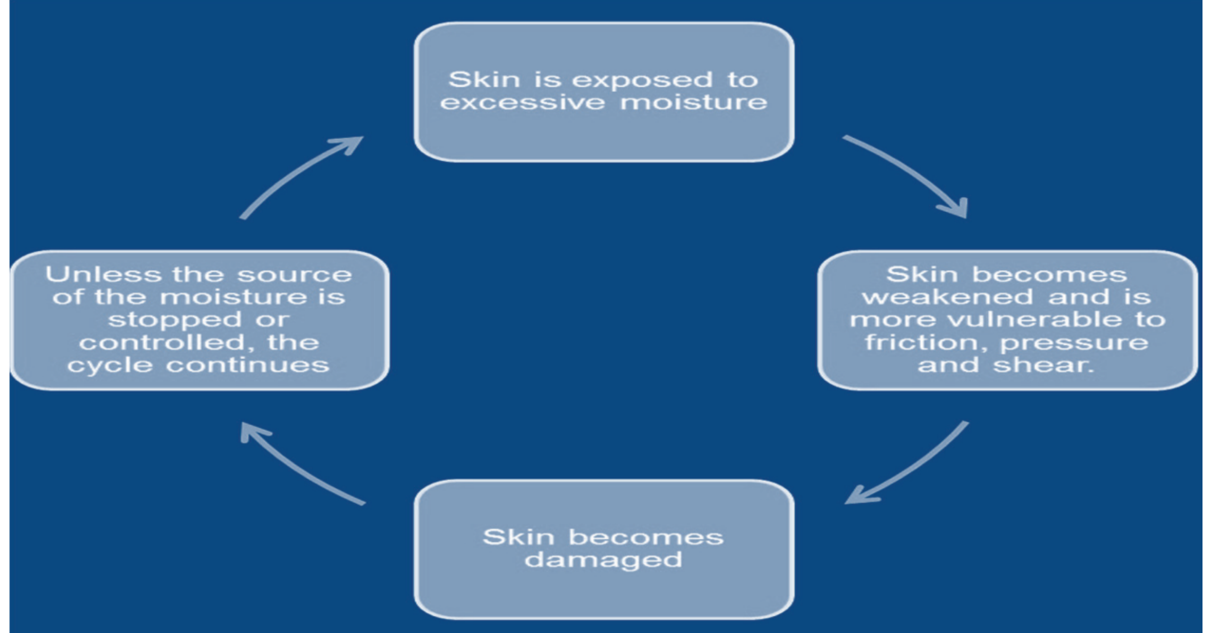
A moisture lesion is soreness and blistering where the skin has been exposed to wetness over a long period of time. This wetness can be urine, faeces, sweat or wound fluid.

Moisture lesions can vary in size, colour and shape. They often appear as patches of sore skin. The skin sometimes blisters and erosions form. They are often irregular in shape. It is common to find them in the skin folds and creases.

Moisture lesions are also known as ‘incontinence associated dermatitis’ and in children as ‘nappy rash’.

One of the first signs that you may have a moisture lesion is a feeling of wetness or irritation on the skin. If you feel wet or sore, it is important to let your nurse or carer know, especially if you need assistance with personal care.

The longer the skin is exposed to moisture, the more damaging it will be. It is important to keep the skin clean and dry to reduce the risk of developing a moisture lesion.



SBAR- Handover tool

S	**SITUATION** • Your name and Care home name • Name of patient , age, DOB • What is the concern, what has happened? Describe symptoms which are different than normal. Does the patient have capacity to tell you what is wrong?	**Examples of symptoms you might describe:** • Falls – are there injuries? • Confused, disorientated, dizzy, unsteady • Drowsy or hard to rouse • Hot / flushed /sweating. Cold / clammy / shivering / pale • Breathing harder or faster, slower or shallower • Complaining of pain, grimacing, posture indicating pain if unable to communicate - describe where pain is • Weakness in legs or arms / facial differences • Coughing / bringing up phlegm / wheezing • Vomiting / nausea - how long for • Change in urinary continence / Smelly urine, blocked or problem with catheter • Change in bowel habit /Diarrhoea • Not eating or drinking / loss of appetite • Bleeding from what area?
B	**BACKGROUND** • How long have symptoms been present? • Did they come on suddenly? • Does the person have any other long term illness? • Have they already been seen by the GP for this change? If so was any medications started? What instructions were given to the home? • Have you got a list of their current medication? • Has the patient recently been into hospital? If so what for? • Does the patient have a current DNAR in place? If yes be clear why you are ringing.	
A	**ASSESSMENT** • What actions have you already taken? Is the patient in a safe place? • Has the person lost consciousness? Be very clear is it a true loss of consciousness? If yes how long for in minutes. • Are there any obvious signs of injury or bleeding?	**Examples of assessment actions you might describe:** • First aid options used /Recovery position • Pressure on bleeding area • BP, Pulse, respiration rate, temperature, urine analysis - give results
R	**RECOMMENDATION** • Explain what you need - be specific about the request and timeframe • Make suggestions i.e. ECP or Dr or advice only • Clarify expectations **Note: an ambulance can take from 9 – 60 minutes depending on urgency**	**Examples of recommendations you might describe:** • Review by GP urgently • Ambulance • Call back from Clinical Advisor • Clarify what is happening as a result of call – when you can expect a visit or ambulance

Remember to document the outcome in the records. Write some answers down before you ring so you don't forget and can give relevant information.

SBAR COMMUNICATION TOOL- AIDE MEMOIRE

FINAL

If an ambulance is sent these are suggestions of what do whilst waiting for the ambulance to arrive?

Reassure the resident and stay with them, continue to monitor for signs of deterioration which may mean a further call to the service. Ask another staff member to follow the check list. Do you need an escort? Do you need to ask senior management to attend the home?

In no particular order:-

1. Inform relatives.

2. Prepare the RED BAG; Photocopy medication charts and bag all medication. Is there any in the fridge, room or cupboards?

3. Photocopy main care plan details or grab sheet making sure the details are up to date. Especially where you have allergies or special instructions around other medical conditions. Include copy of DNAR form. Is there any special information which may help staff to communicate or deliver care for the resident, (i.e. strategies to adopt when the patient is anxious especially with dementia residents)? Are there any triggers which are not recorded?

4. Prepare an overnight bag for the resident. Remember to take items that may offer reassurance. Maintaining the residents' dignity is paramount so having their own belongings may help.

Single point of access

Service	When to contact	How to contact
Emergency Care Practitioner (ECP)	**If your resident is suffering from symptoms of** • Head injuries (without loss of consciousness) • Wounds • Burns & scalds • Joint & limb injuries • Soft tissue injuries • Rib injuries • Back pain • Chest infections • Urinary tract infection • Dizziness/Vomiting Minor allergic reactions	**Call:** **0345 601 0552** **06:30-23:00 hrs seven days a week** **Ensure you are with your resident when you call.**
CALL 111 when it's less urgent than 999	**For out of hours health advice from** • GP • Palliative care nurse, • Mental health nurse, • Pharmacist • Dentist	**Call:** **111** **24 hours a day 7 days a week** **Ensure you are with your resident when you call.**
End of Life	**The Palliative Care Referral Centre provides advice as a 1st point of contact for palliative and end of life patients.**	**Call:** **0333 234 0868** **Monday to Friday 9am - 5pm** **Saturday, Sunday and Bank Holidays 10am - 2pm** **Specialist Palliative Care advice is available 24 hours a day** **020 3826 2377.**
Mental Health	**Contact for advice relating to:** A resident experiencing a mental health problem for the first time or is in need of urgent help. (If your resident is already using the service contact their case worker).	**Call:** **0300 777 0707** **24 hours a day 7 days a week**

Single point of access

Service	Description	Contact
Community Adult Health Services (CAHS)	**Community nurses, community matrons, physiotherapists, occupational therapists and specialist palliative care nurses who support with:** • Wound care management • Chronic disease management • Palliative treatment and care • Injections/eye drops • Tissue viability • Leg ulcer management • Bladder and bowel management • PEG management • Therapy assessments and treatments	**Call:** **01727 732001** **8am to 10pm** **7 days a week**
Wheelchair service	**Provide wheelchairs and equipment such as:** • Manual wheelchairs • Powered indoor and outdoor wheelchairs • Specialist buggies, wheelchairs and seating for children • Specialist bespoke seating systems for use with a wheelchair • Pressure relieving cushions and some accessories for wheelchairs	**Call:** **0333 234 0303** **8.00am to 5.00pm Mon-Fri** **For current wheelchair users.** *New users should be referred into the service by a qualified healthcare professional such as a GP, district nurse, physiotherapist, occupational therapist.
Community Speech and Language Therapy (SLT)	**Contact for advice and support relating to:** • Difficulties with communication, eating, drinking and swallowing • Newly identified or as a result of medical conditions, such as stroke, head & neck cancer, parkinson's disease and dementia	**Call:** **01438 285287** **9.00am to 5.00pm Mon-Fri**
Community Diabetic nursing team	**Contact for advice relating to:** • Advice and education for adults with diabetes • Healthy living • Diabetes treatments • Initiation of insulin • Blood glucose monitoring and how to use a glucometer	**Call :** **01707 621152** **9am–5pm Mon - Fri**

Single point of access

Community Dieticians	**Contact for advice and support relating to:** • Diabetes and weight Management • Nutrition support • Home enteral tube feeding • Long term conditions	**Call:** **01727 732011** **9am-5pm Mon – Fri**
Community Respiratory team	**Contact for advice and support relating to:** • Pulmonary rehabilitation • Home oxygen • Hospital at home • Community respiratory clinic • Chronic obstructive pulmonary disease (COPD) • Asthma • Bronchiectasis • Interstitial lung disease (ILD) • Obstructive sleep apnoea (OSA) • Non-invasive ventilation (NIV); and tuberculosis nursing service	**Call:** **07944 960825** **Mon - Fri 9am to 5pm**
In an Emergency: 999	**FOR LIFE OR LIMB THREATENING EMERGENCIES ONLY**	**Call:** **999** **24 hours a day 7 days a week**

Thank you

Any questions?