



Humber and North Yorkshire
Health and Care Partnership



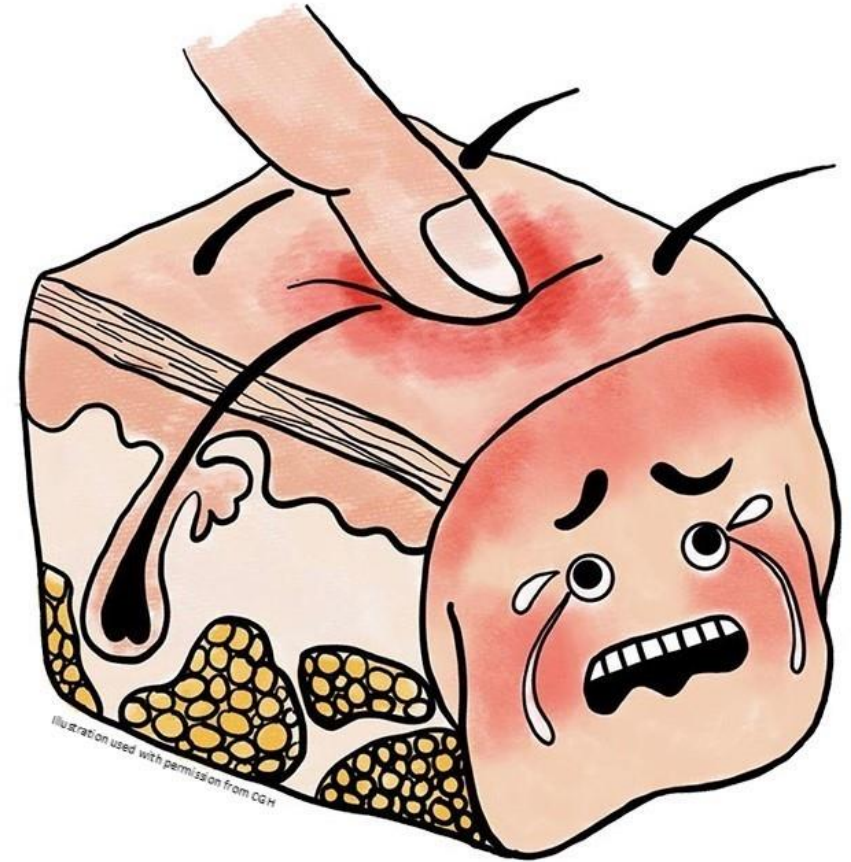
**Humber and
North Yorkshire**
Integrated Care Board (ICB)

Preventing Pressure Ulcers



What is a pressure ulcer?

“A Pressure Ulcer is localised 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 or as an open ulcer and may be painful”
(NHS I,2018)



Awareness

The Skin is the body's biggest organ

Treating pressure ulcers costs the NHS more than £1.4 million every day (Guest et al. 2017)

Pressure ulcers in older patients are associated with a fivefold increase in mortality. In addition, in-hospital mortality in this group is 25% to 33% (Grey, 2006).

Individuals admitted to care homes should have a risk assessment completed with 6 hours of admission (NICE 2015)

Pressure ulcers were found in Egyptian Mummies more than 5000 years ago and treated with honey

High risk individuals can develop a pressure ulcer in 1-6 hours after sustained pressure

In some cases, the damage may not be present for a few days

According to research pressure ulcers in care homes are commonly found in malnourished females and obese males



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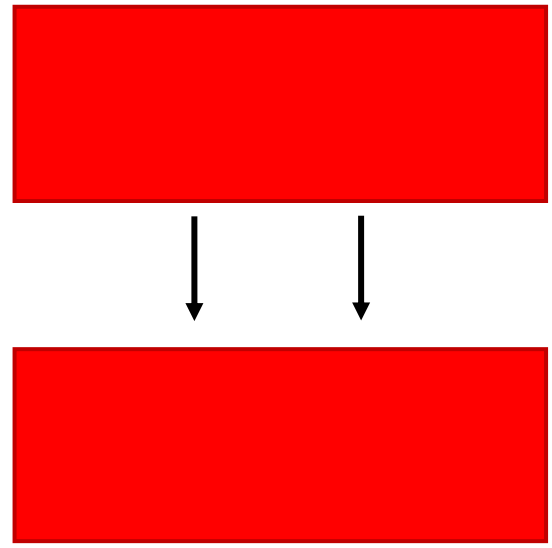


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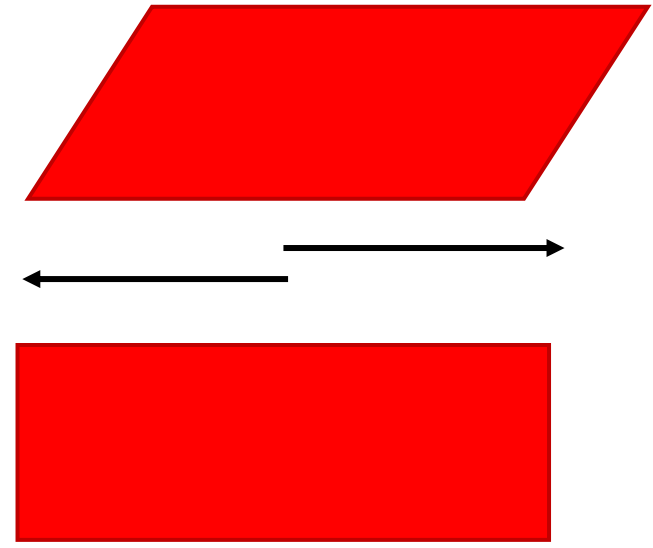


[European Pressure Ulcer Advisory Panel \(epuap.org\)](http://www.epuap.org)

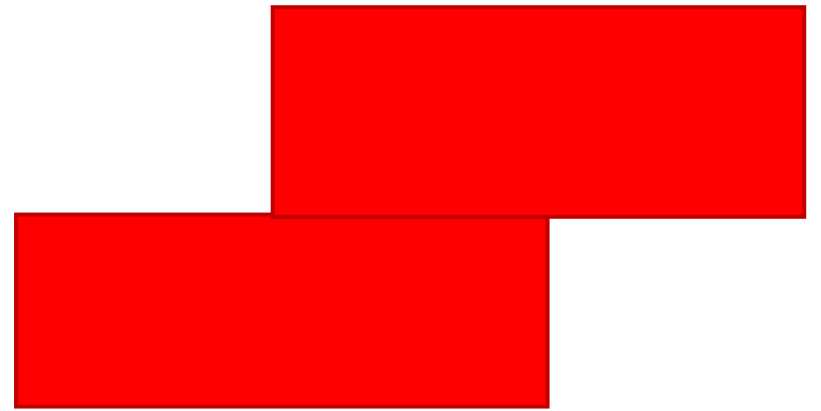
Pressure



Shear



Friction





Risk Factors

Sensory
impairment

Continence

Levels of
consciousness

Posture

Cognition

Previous pressure
ulcer

Illness/diseases –
diabetes, Parkinson's
disease, previous stroke,
heart failure, arthritis,
kidney failure, EOL.

Age

Oral intake

Mobility





Pressure Ulcer Implications

Financial implications

The estimated cost to the NHS and Care organisations in the UK is around £6.5 billion per year

Financial implications to resident and carers/ relatives

Service User implications

Pain and discomfort

Enforced bed rest/ reduced mobility

Social isolation and depression

Excessive hospital stay/ increased dependency

Complications such as infection with potential for sepsis – morbidity/mortality

Quality experience

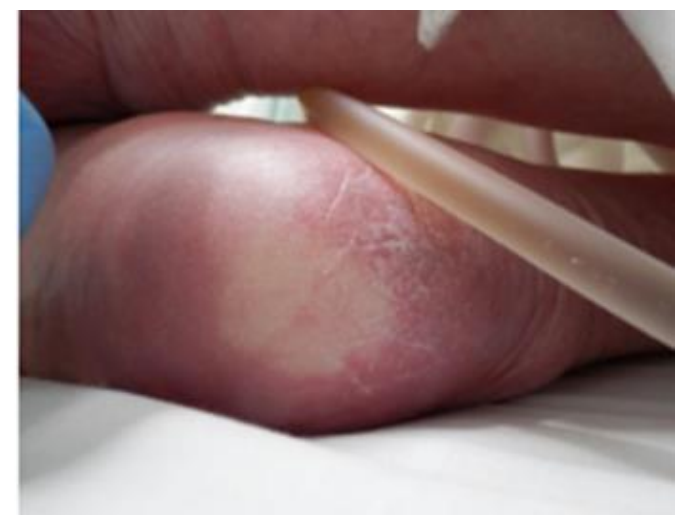
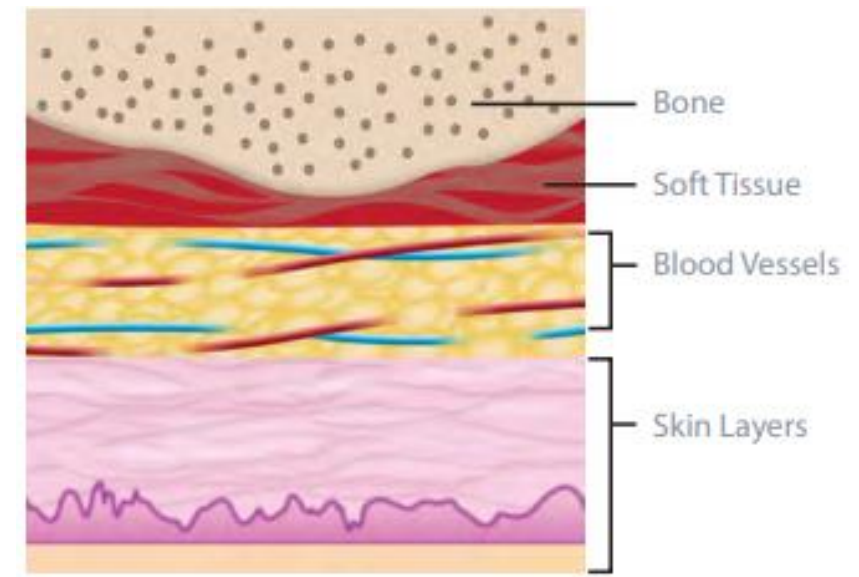
Avoidable pressure ulcers are a key indication of the quality and experience of care

The development of pressure ulceration can be potentially regarded as indicative of poor care or neglect



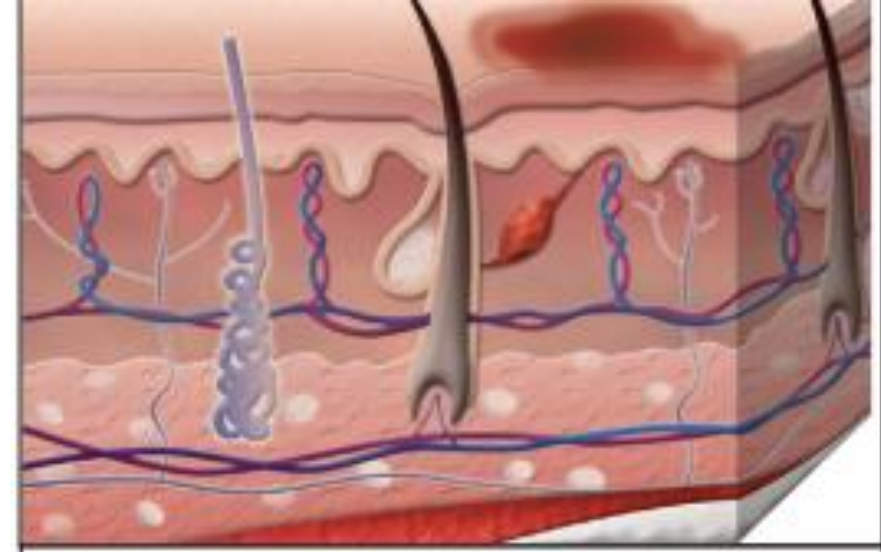
Pressure ulcer categorisation

Blanching erythema – not a pressure ulcer





Category 1: Non-blanchable erythema

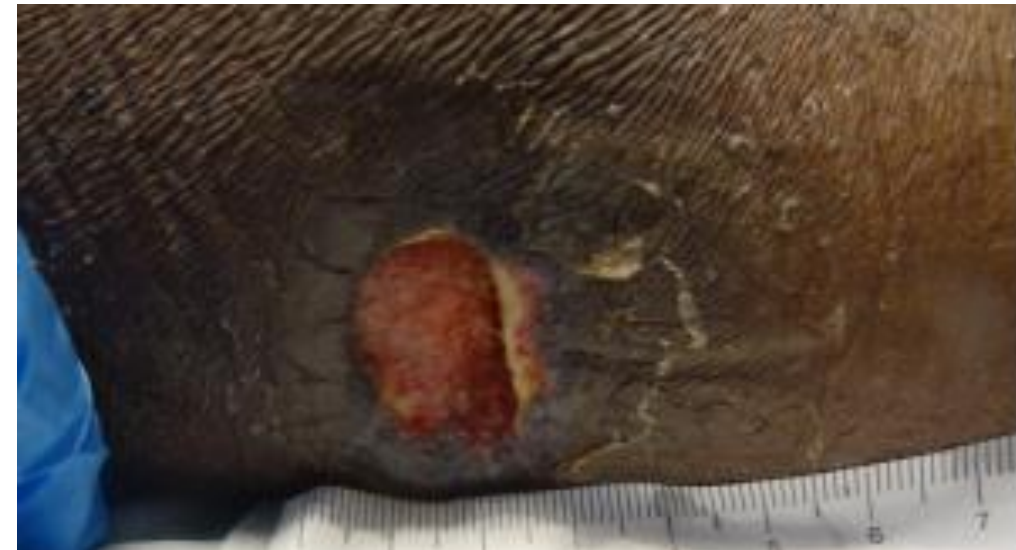
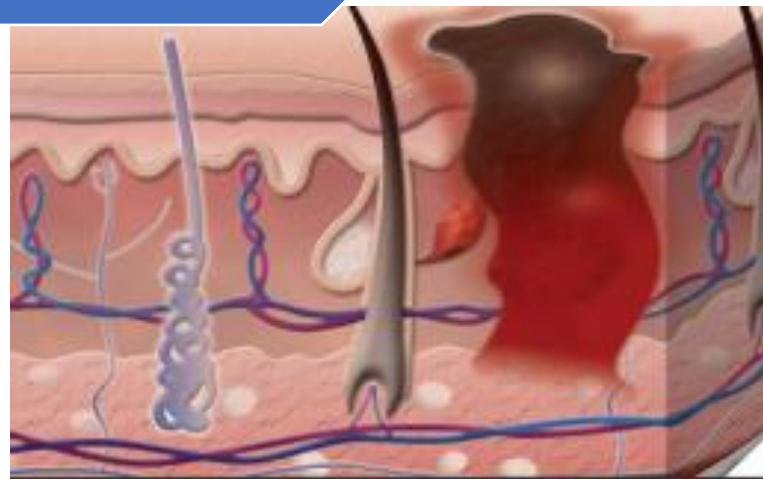


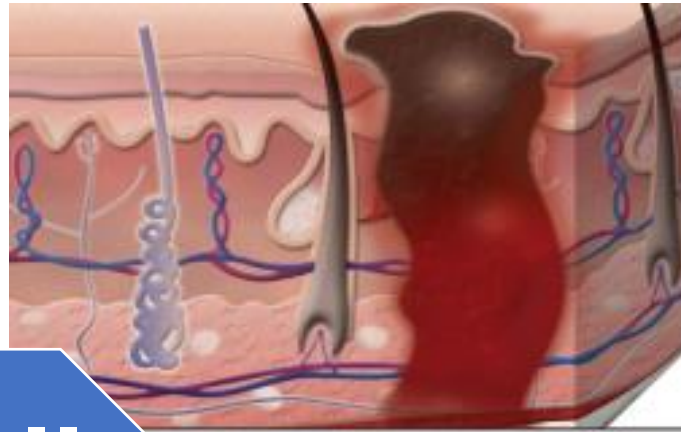
Category 2: Partial thickness skin loss





Category 3: Full thickness skin loss





Category 4: Full thickness tissue loss





**Unstageable:
depth unknown**





Name 4 ways a pressure ulcer can affect someone's quality of life?

- Pain
- Need to stay in bed to relieve pressure
- Can be very isolating
- Smell

What are 6 things we can do to prevent pressure area breakdown?

- Assess pressure ulcer risk regularly
- Help people to keep hydrated and to have a nutritious diet
- Help people to keep moving
- Help people to keep skin clean and dry
- Inspect the skin
- Use of pressure-relieving aides

Which group are most likely to develop pressure ulcers?

- Older people



“Inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture ‘NHS Improvement Pressure ulcer categorisation group (2019) Pressure Ulcer Categorisation “

Moisture associated Skin damage

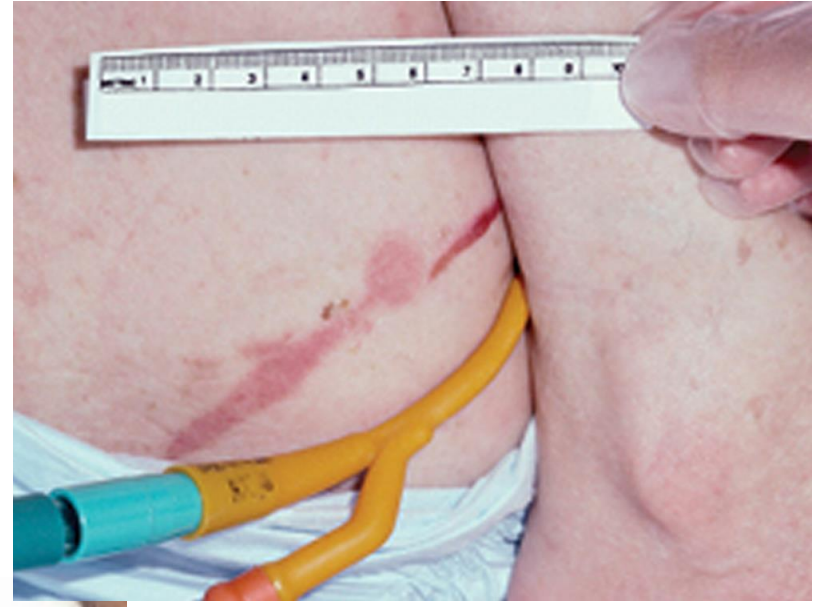


Category 1 or Moisture associated skin damage?





Device related pressure damage





Assessment of risk

- Everyone
- Holistic
- Risk factors
- Who?
- Frequency?
- What are you looking for?
- Changes

Did you know that pressure ulcers affect around 20% of people in nursing and residential homes?



Who is at risk?

RISK	GREEN	AMBER	RED
SKIN	INTACT/PINK	SWOLLEN	REDDENED/BROKEN
MOISTURE	CLEAN DRY SKIN/ WELL HYDRATED	SWEATY/ MOIST SKIN	WET/ INCONTINENT
WEIGHT	NORMAL	OBESE	UNDERWEIGHT
SENSATION	NO IMPAIRMENT	LIMITED	UNRESPONSIVE
MOBILITY	ACTIVE	NEEDS ASSISTANCE	BED-RIDDEN
DRUGS	LOW	MEDIUM	HIGH
GENERAL HEALTH	HEALTHY	COMPROMISED	POOR

For more information visit www.stopthepressure.com

Braden Risk Assessment Scale

NOTE: Bed and chair-bound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Patients with established pressure ulcers should be reassessed periodically.

Patient Name: _____ Room Number: _____ Date: _____

	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment
Sensory Perception	Unresponsive to pain, temperature, pressure, or other sensations. (0)	Responds only to moderate or severe pain. (1)	Responds to mild or moderate pain. (2)	Responds to mild or moderate pain. (3)
Moisture	Moisture in bed or on skin causes discomfort or irritation. (0)	Moisture in bed or on skin causes discomfort. (1)	Moisture in bed or on skin causes discomfort. (2)	Moisture in bed or on skin causes discomfort. (3)
Activity	Unable to change position. (0)	Unable to change position. (1)	Unable to change position. (2)	Unable to change position. (3)
Transfer	Unable to move without assistance. (0)	Unable to move without assistance. (1)	Unable to move without assistance. (2)	Unable to move without assistance. (3)
Continence	Unable to control bladder or bowels. (0)	Unable to control bladder or bowels. (1)	Unable to control bladder or bowels. (2)	Unable to control bladder or bowels. (3)
Friction and Shear	High friction and shear. (0)	High friction and shear. (1)	High friction and shear. (2)	High friction and shear. (3)

Total Score: _____

Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Step 1 – screening

Step 2 – full assessment

Step 3 – assessment decision

Pressure Ulcer Risk Assessment – PURPOSE T (V2) is a tool for assessing the risk of pressure ulcers. It is used to identify patients at risk of developing pressure ulcers and to guide the development of a care plan to prevent or reduce the risk of pressure ulcers.

Surface

Risk

Mobility

Cognition

Perception

Maintenance





Skin inspection

Observe

Changes to skin?

Document

Report/escalate

Frequency

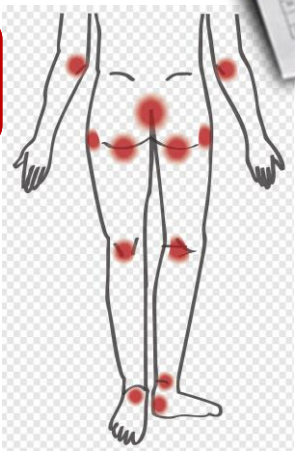
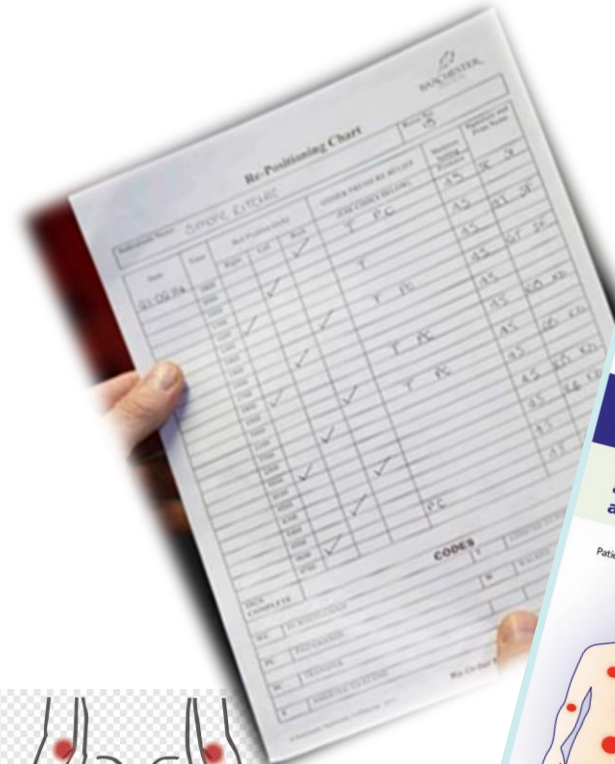


Fig 1 How to keep skin healthy

Skin inspection guide
Check most vulnerable areas and document pressure areas at least once a day

Great SKIN

Patient name: _____ Date: / /

GREEN
No signs of pressure damage: Continue to inspect skin daily and encourage regular repositioning.

AMBER
Early signs of pressure damage: Monitor patient closely on pressure ulcer prevention plan / SSKIN bundle. Carers must inform qualified nurse/ community nurse.

RED
Pressure damage: This must be documented immediately on a wound assessment chart and prevent further damage, management plan / SSKIN bundle. Inform tissue viability nurse specialist and GP.

Are there any signs of pressure damage?
Redness/erythema Yes No
Non-blanching persistent erythema Yes No
Pain/itchiness Yes No
Warm/cooler over bony prominence Yes No
Boggy feeling Yes No
Hardened Yes No
Discolouration* Yes No
Broken skin Yes No

Name: _____
Action: _____

Source: bit.ly/StPHHealthySkin

Midlands and East

The Skin Tolerance Test also known as the Blanch Test

There is a simple test you can do to see if there is skin damage and a possible pressure ulcer developing.



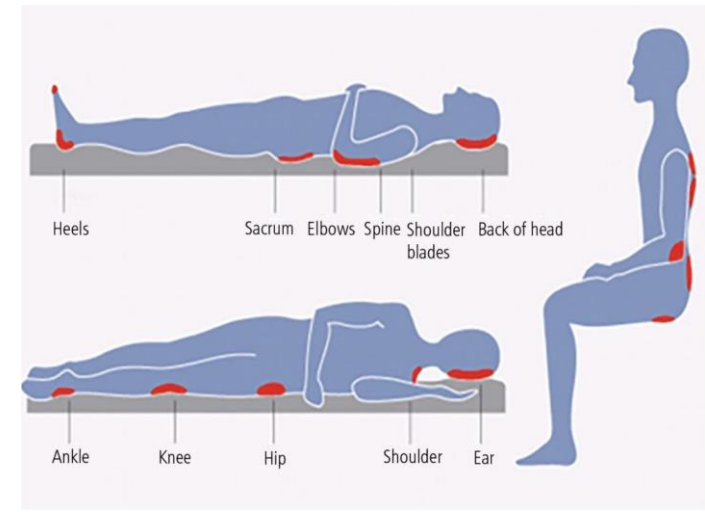
Normal skin response to pressure, like your elbow when you lean on it.



Press finger over reddened area for 5 seconds, then lift up finger.



If the area blanches, it is not a stage 1 pressure ulcer. If it stays red, it is a stage 1 pressure ulcer.





Keep moving

Mobility

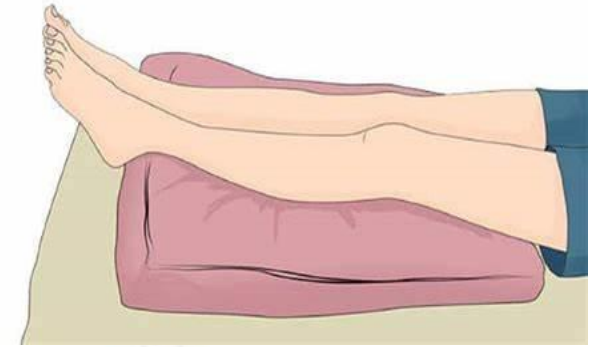
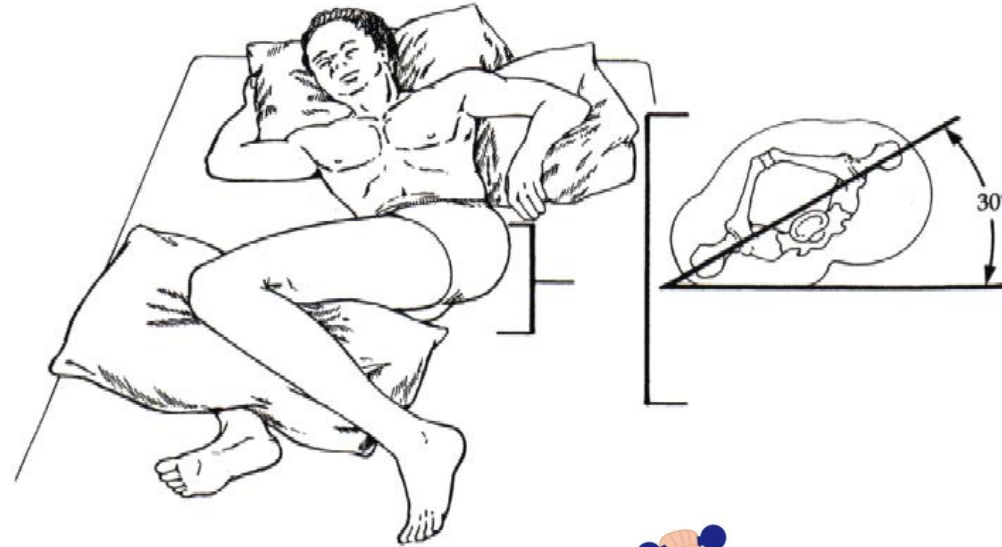
Moving and handling

Equipment

Repositioning

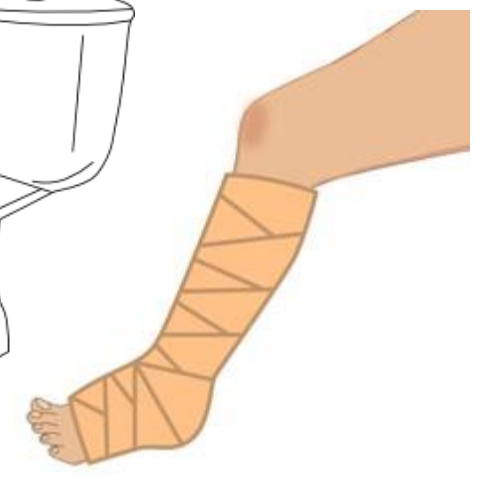
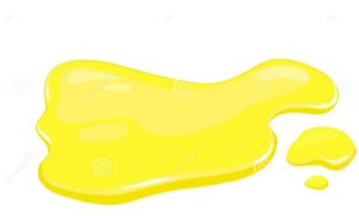
30 degree tilt

Offloading



Incontinence and moisture

- Hygiene
- Barrier creams
- Emollients
- Managing incontinence
- Infection
- Cotton clothing
- Underwear





Nutrition and Hydration

MUST Score

Food and fluid charts

1500ml fluid

Food fortification

Likes and dislikes

Underlying causes?

Supplements

Who needs help?

'Malnutrition Universal Screening Tool' MAG

'MUST'

'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

It is for use in hospitals, community and other care settings and can be used by all care workers.

This guide contains:

- A flow chart showing the 5 steps to use for screening and management
- BMI chart
- Weight loss tables
- Alternative measurements when BMI cannot be obtained by measuring weight and height.

The 5 'MUST' Steps

Step 1
Measure height and weight to get a BMI score using chart provided. *If unable to obtain height and weight, use the alternative procedures shown in this guide.*

Step 2
Note percentage unplanned weight loss and score using tables provided.

Step 3
Establish acute disease effect and score.

Step 4
Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5
Use management guidelines and/or local policy to develop care plan.

Please refer to The 'MUST' Explanatory Booklet for more information when weight and height cannot be measured, and when screening patient groups in which extra care in interpretation is needed (e.g. those with fluid disturbances, plaster casts, amputations, critical illness and pregnant or lactating women). The booklet can also be used for training. See The 'MUST' Report for supporting evidence. Please note that 'MUST' has not been designed to detect deficiencies or excessive intakes of vitamins and minerals and is of use only in adults.



Giving information

- Communication
- Educate
- Inform
- Seek advice
- Escalate
- Document





Resources

<https://www.e-lfh.org.uk/programmes/wound-care-education-for-the-health-and-care-workforce/>

<https://www.nationalwoundcarestrategy.net/pressure-ulcer/>

React To Red: Pressure Ulcer Prevention : Training resources



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