Nottinghamshire Healthcare
NHS Foundation Trust

REACT TO RED

Pressure Ulcer Prevention

Training Pack for Care Homes & other Care Providers

REACT TO RED

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REACT TO RED

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Introduction

Pressure ulcers are not just a modern day problem and historically were referred to as bed sores, pressure sores and decubitus ulcers.

The elderly in care homes are a particularly vulnerable group, often suffering with age associated illnesses, co-morbidities and poor mobility. All of which vastly increase their risk of developing pressure ulcers.

The estimated cost to the NHS is enormous and it is cited at being between £1.4 billion and £2.1 billion a year (Large, 2011; NICE, 2005).

Many of the guidelines and literature state that early identification is vital in pressure ulcer prevention, so **REACT to RED** and prevent rather than cure.

> *"There are more than half a million new pressure ulcers in the UK in any one year. This is a massive level of harm for our patients and one that is largely avoidable.*
>
> *As workers looking after our most vulnerable patients I want you to think...'do I know who's at risk of pressure ulcers, do I know how many [people with] pressure ulcers I've got, do I know what interventions I've got in place for each individual patient to prevent them getting worse and to heal them as soon as possible?'"*
>
> **Denise Nightingale**
> **Chief Nurse for Bassetlaw Clinical Commissioning Group**

NOTE:
As healthcare providers we have a **duty of care** to prevent and reduce harm. A duty of care is defined simply as a legal obligation to:

- Always act in the best interest of individuals and others
- Not act or fail to act in a way that results in harm
- Act within your competence and not take on anything you do not believe you can safely do

Everyone has a duty of care - it is not something you can opt out of.
Nursing and Midwifery Council, (2008)

How to use this Training Pack

This easy to use training pack is a resource for your care home and other care providers

This training pack has been produced for care homes and other care providers and for consistency the term 'resident' has been used throughout. Although the term resident has been used, this is an essential resource for anyone caring for those at risk of developing pressure ulcers.

It will give staff the necessary knowledge and skills to reduce the incidence of pressure ulcers.

For effective use we recommend:

1. **Staff watch the DVD**

2. **Work through the competencies using the information pack as a resource**

3. **Your Link Champion should review the completed competencies**

The Facts

What is a pressure ulcer?

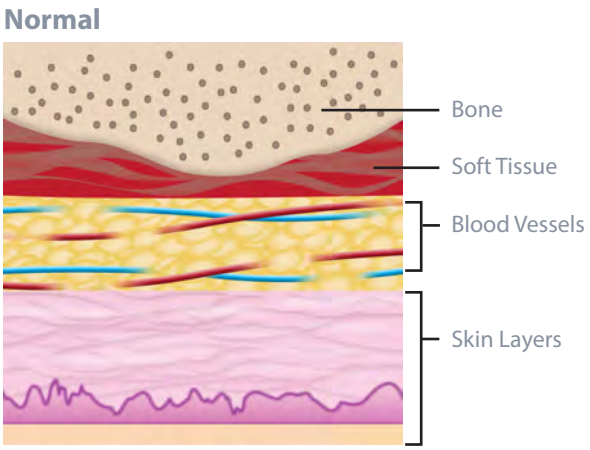
A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. (EUPAP: 2014).

How does a pressure ulcer occur?

The first sign of tissue damage is redness.

Pressure ulcers can occur over a short period of time if a large amount of pressure is applied, but they can also occur over a longer period of time when less pressure is applied.

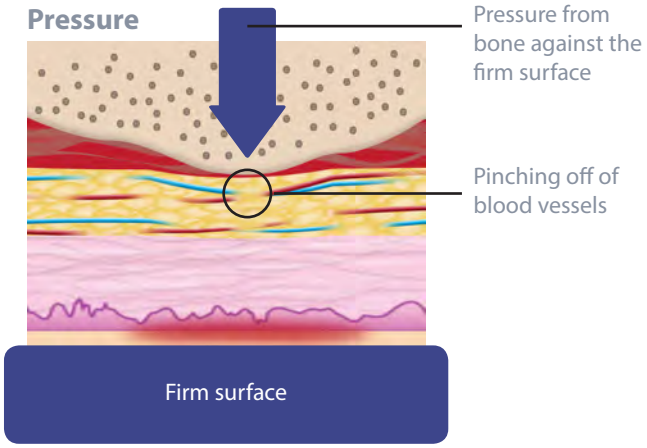
A larger amount of pressure increases the damage from shearing force.



Pressure

When skin and tissues are directly compressed between two hard surfaces such as bone and bed, or bone and chair, the blood supply is disrupted and the area is starved of oxygen and nutrients and tissue damage begins.

Example
A person sat in one position unable to move independently for a long period.

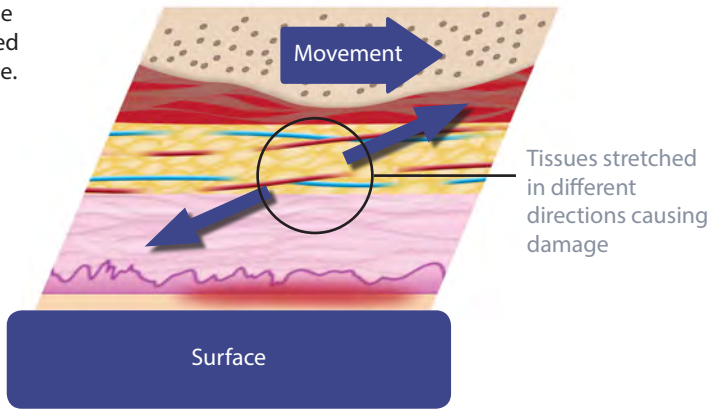


Shear

When tissues are stretched in different directions, the skin stays static and the tissues underneath are pulled in opposing direction causing internal tissue damage.

Example
When a person slides down the bed or chair.

Shear

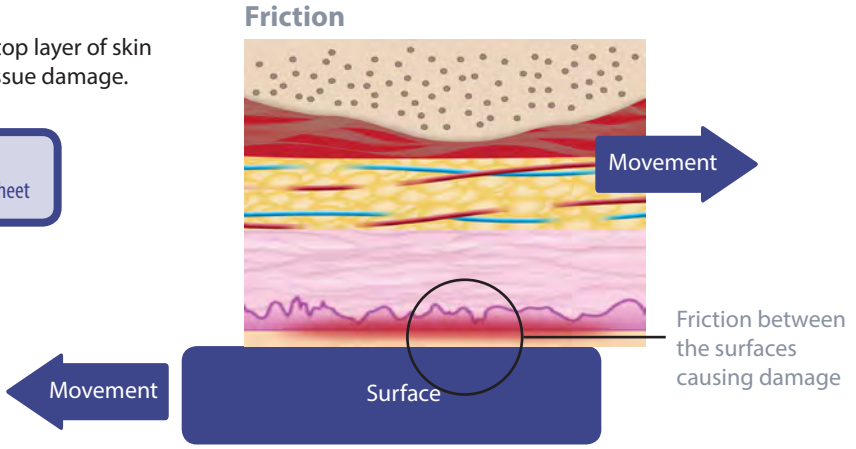


Friction

When two surfaces rub together the top layer of skin gets stripped away contributing to tissue damage.

Example
When a persons heels rub on the mattress or sheet

Friction



The impact of pressure ulcers

Impact on residents

Pressure ulcers have a huge impact on the resident's quality of life causing increased pain, risk of infection, depression, low self esteem and often embarrassment due to the odour.

Impact on you

The impact on residents will directly impact on you causing increased workload and demands on your time. Seeing your resident suffering may also cause you distress. You have a duty of care (see page 4), and the risk of litigation.

Impact on your care home

Cost of care increases causing financial burden. Pressure ulcers can be indicative of the quality of care given at your home and may damage your reputation. Governing bodies are informed and may investigate.

Risk factors

Risk assessment is understanding a residents likelihood of developing a pressure ulcer

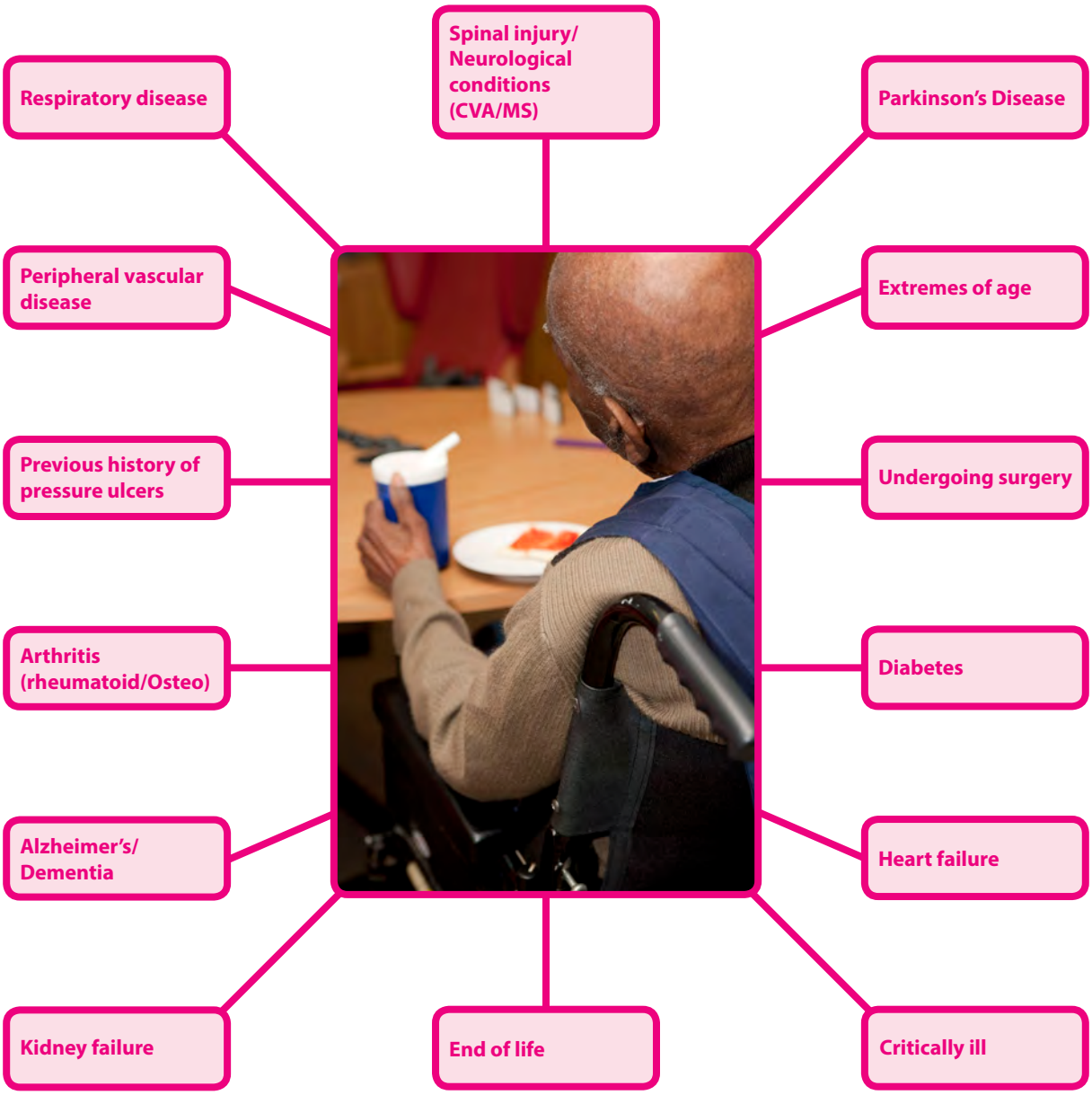
To do this you need to understand the risk factors. These could be:

- **Pressure**
- **Shear**
- **Friction**
- **Mobility**
- **Sensory impairment**
- **Continence/moisture**
- **Level of consciousness**
- **Posture**
- **Cognition**
- **Previous pressure damage**
- **Age**
- **Nutrition and hydration**
- **Illness/disease**

Risk factors	What is it?	Why this increases the risk of developing ulcers?
Pressure	When skin and tissues are directly compressed between two hard surfaces	Because it squashes the blood vessels and reduces the blood supply which starves the area of oxygen and causes the tissue to die
Shear	When tissues are stretched in different directions	The skin stays static and the tissues underneath are pulled in opposing direction causing internal tissue damage
Friction	When two surfaces rub together	The top layer of skin gets stripped away contributing to tissue damage
Mobility	Ability to change and control body position	Staying in one position increases the time that pressure is applied to one area
Sensory impairment	Reduced ability to feel pain or discomfort OR the reduced ability to communicate pain or discomfort	The inability to respond to your body telling you to move to prevent pressure damage
Incontinence & moisture	Skin that is exposed to urine, faeces and moisture (from sweat and wound leakage)	Over a period of time these will destroy the protective layer of the skin and make the area more vulnerable to tissue damage
Loss of consciousness	Involves complete or near-complete lack of responsiveness to people and other environmental stimuli	This means that a person will not be able to control their own bodily function and therefore all other risk factors will now apply (as listed above)
Posture	The way in which your body is positioned	A poor posture when sitting, standing or lying down will increase pressure through one area or several areas
Previous pressure damage	Pressure damaged tissue that has now healed	The new tissue is weaker and therefore more vulnerable to damage
Age	Length of life	As you age you are at increased risk of skin damage because the skin is thinner, more fragile and the protective fatty layer is lost
Nutrition & hydration	To take food and drink essential for life	For your skin to remain healthy, it requires nutrients that can only be supplied by receiving a nutritious diet and enough fluids. Without these nutrients our skin is more vulnerable to break down If weight loss occurs vulnerable bony prominences that are not protected by fatty tissue will be prone to pressure damage

Risk Assessment

What to look for?



Prevention is Better Than Cure

Now you understand the risk factors if you feel your resident is vulnerable in developing a pressure ulcer there are some simple steps you can take to protect your resident from the harm caused by pressure ulcers.

The next few chapters will guide you through each of the steps.

Prevention is Better Than Cure

Surface

S **Surface**

Make sure your residents have the right support

If your resident is not very mobile and unable to change their own position they need the surface they are using to be reviewed regularly.

TOP TIPS:

Foam

- Check the 'bounce' by pressing with a your hand to see if it springs up. If the mattress does not feel springy then it may need replacing
- Check that it is clean and not contaminated
- Check there are no cracks, tears or splits

Air

- All airflow overlay mattresses MUST be on a full thickness foam mattress
- Check that the settings are set against the resident's weight (this will be in the instructions – or on the control box)
- Check it is plugged in, turned on and inflated during each shift
- Listen for the alarms and respond as they are a warning something is wrong
- Only cover with a single loose sheet between your resident and the mattress. Fitted sheets will reduce the effect of the mattress
- Only use prescribed incontinence pads for incontinent residents and do not add additional layers underneath as this will reduce the level of pressure relief

Mattresses

As a minimum your resident should have a foam pressure relieving mattress. Residents who are unable to change position in bed should have an air mattress.
For provision of mattresses see guide opposite.

Cushions

As a minimum, unless your resident is able to change position independently whilst sitting, they should be provided with a pressure relieving cushion.

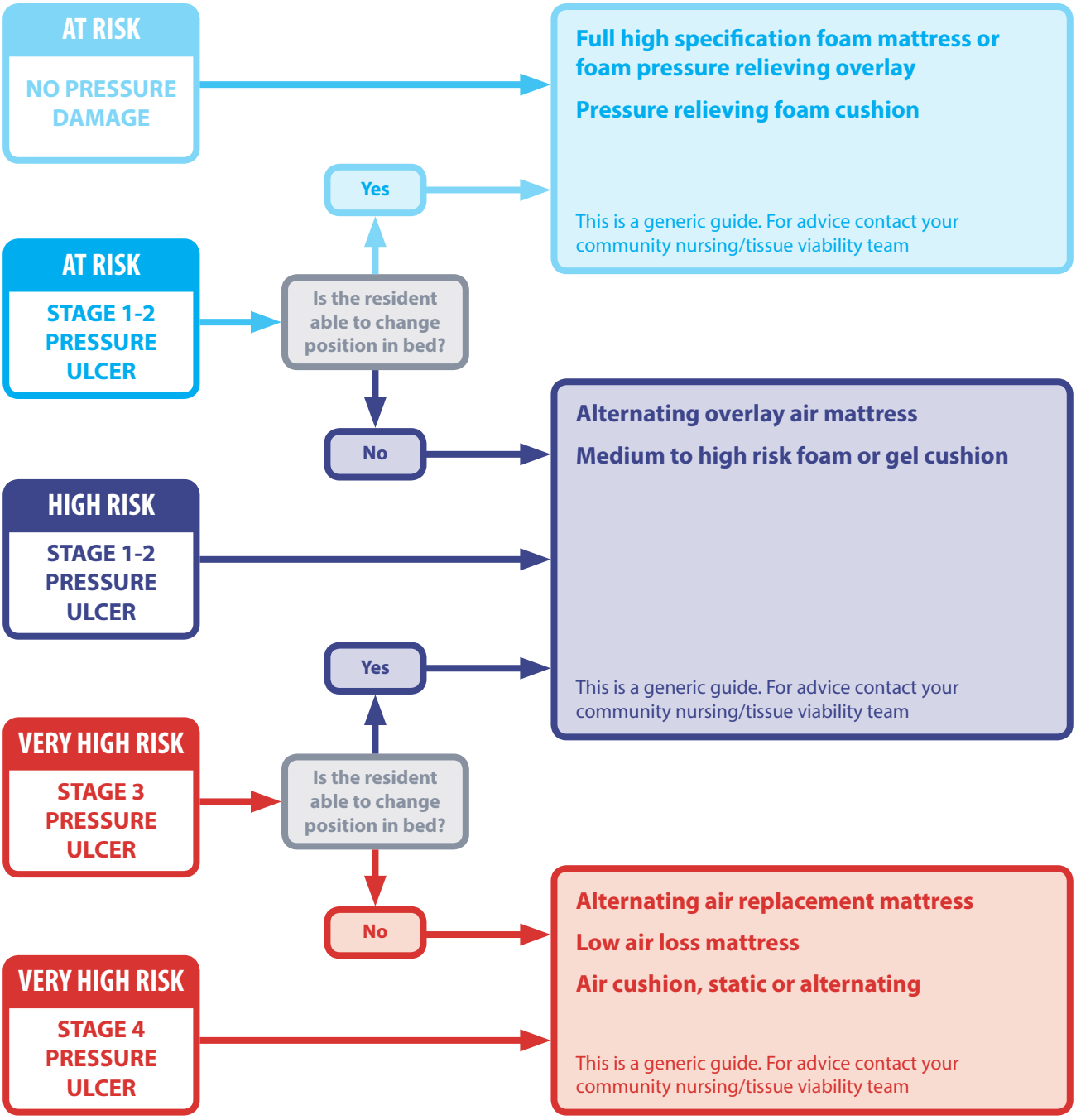
If your resident is a permanent wheelchair user they should be assessed by wheelchair services for a pressure relieving cushion. Refer to Wheelchair Services if a further assessment is required.
Please refer to the guide opposite for provision of cushions.

Bad example

Good example

A guide for the provision of support surfaces

The equipment protocol is designed as a guide only and should always be used in conjunction with your **clinical judgement**.



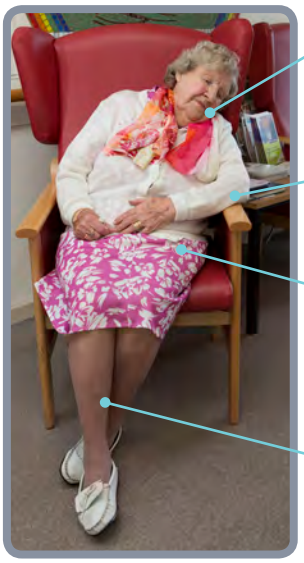
Seating

A poorly seated resident will have an increased risk of pressure damage due to their position.

TOP TIPS:

- Wherever your resident goes so does their cushion for every chair they sit in
- Check the bounce if foam or air
- Check intact if a gel cushion
- Gel cushions should be kneaded regularly to redistribute the gel evenly
- Check that it is clean and free from contamination
- Check there are no cracks, tears or splits

Good sitting position



Bad sitting position

Head slumped to side and forward - restricts breathing, ability to swallow and communication.

Elbow under increased pressure with the body slumped to one side.

Being slumped there is an increased risk of shear damage. Also more pressure to one side of the body, particularly the shoulder blades and ischial tuberosity (bottom).

Crossed legs can increase pressure to the heel in contact with a surface which also restricts blood flow.

Impact on YOU

A well seated resident could potentially have less demand on your time to provide care.

What you must do?

- Check that your resident is on the right surface according to the guide
- Check if they need equipment appropriate to their size and weight? Are they quite tall? Is your resident over the weight limit for their specified cushion/mattress?
- Check if their shoes fit properly – is the sole hard or are their toes/feet marking?
- Do they have/need a specialised chair or wheelchair? If they have when was it last serviced?
- Check the condition of the cushion/mattress. Has it lost its bounce? Is it damaged?

If the equipment is not suitable for your resident or you answer yes to any of the above, you MUST report it to your senior member of staff or your Tissue Viability Link Champion.

Prevention is Better Than Cure

Skin Inspection

S **Skin Inspection**

Early inspection means early detection. Show residents and carers what to look for

Take your BEST SHOT!

- **B** - **BUTTOCKS** (ischial tuberosities)
- **E** - **ELBOWS/EARS**
- **S** - **SACRUM** (bottom)
- **T** - **TROCHANTERS** (hips)
- **S** - **SPINE/SHOULDERS**
- **H** - **HEELS**
- **O** - **OCCIPITAL AREA** (back of head)
- **T** - **TOES**

The most effective way to prevent pressure ulcers developing on your residents is to **LOOK** at all the areas which are at risk from pressure damage at every opportunity (as a minimum - morning and at night).

What to look and feel for?

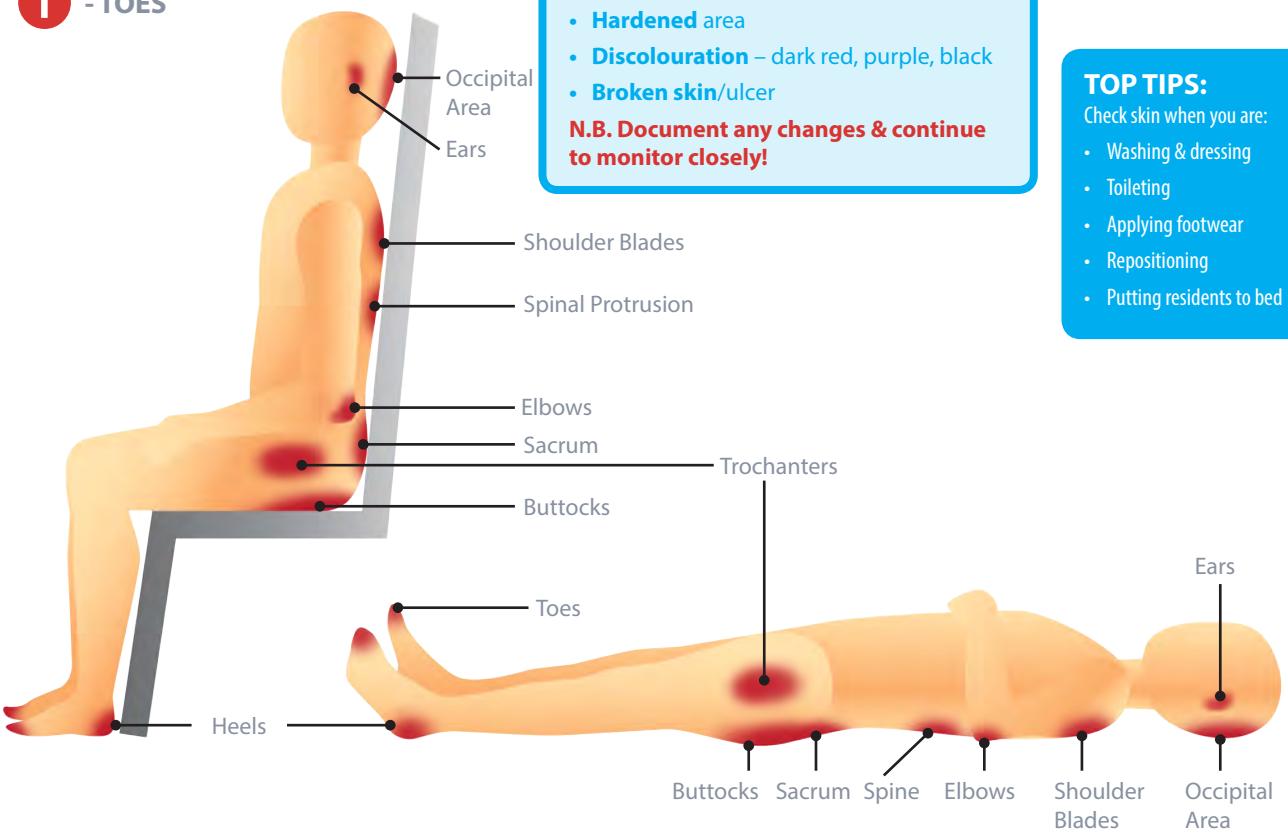
- **Redness**/erythema - non-blanching when finger pressure applied
- **Pain, soreness**
- **Warmer** or **cooler** area over bony prominence
- **Boggy** feeling
- **Hardened** area
- **Discolouration** – dark red, purple, black
- **Broken skin**/ulcer

N.B. Document any changes & continue to monitor closely!

TOP TIPS:

Check skin when you are:

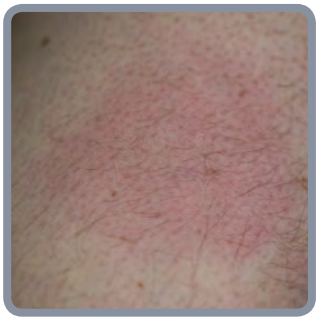
- Washing & dressing
- Toileting
- Applying footwear
- Repositioning
- Putting residents to bed



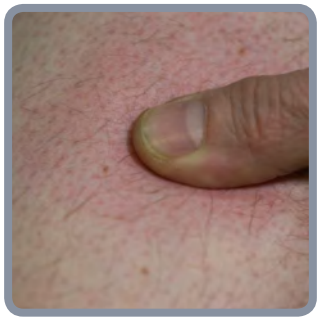
University Hospitals of Leicester NHS Trust, (2010).

The Skin Tolerance Test also known as the Blanch Test

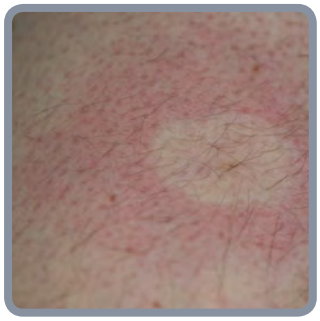
There is a simple test you can do to see if there is skin damage and a possible pressure ulcer developing.



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.

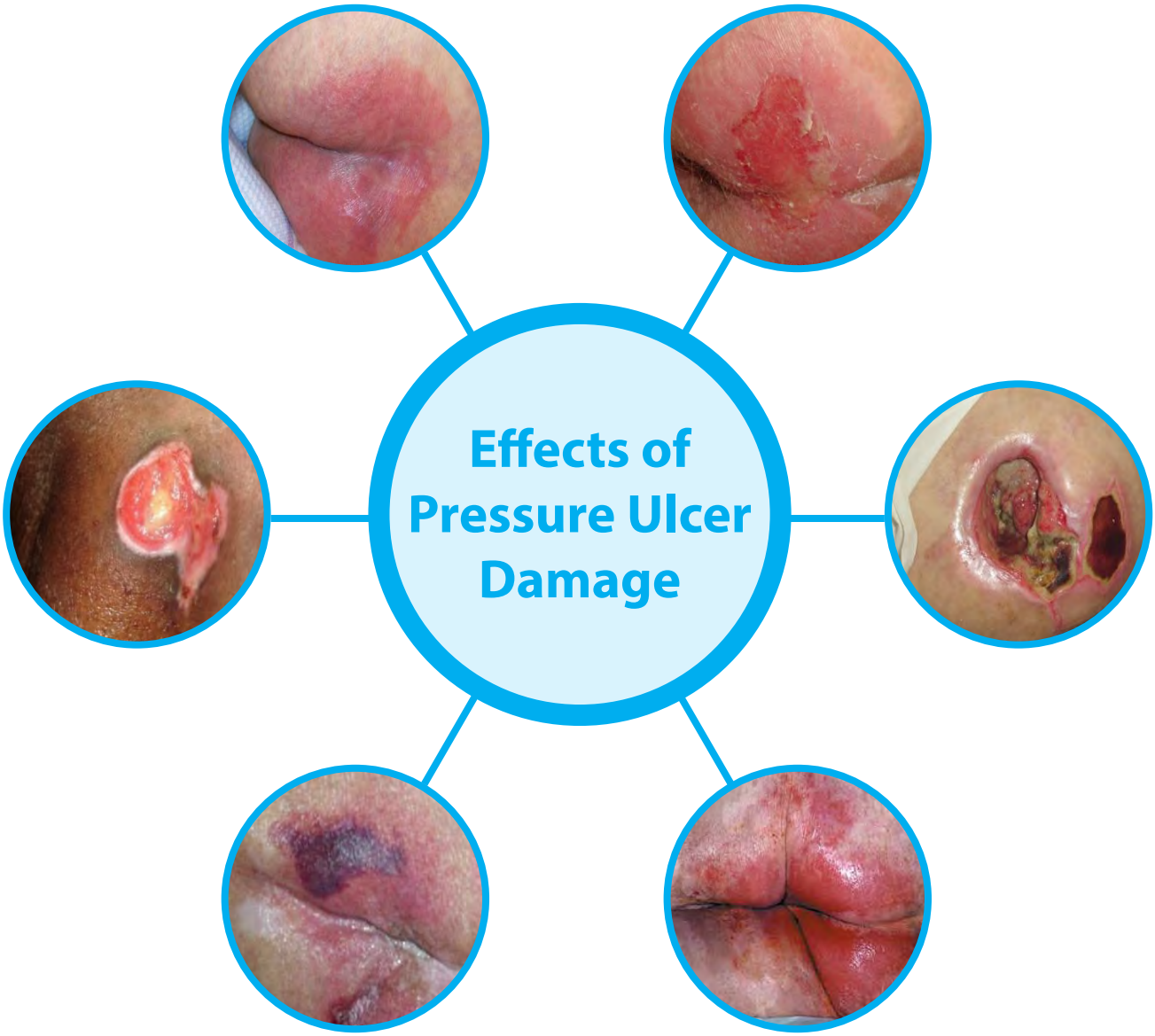
NOTE:
Darkly pigmented skin does not blanch. Signs to look for in early tissue damage include purple discolouration, skin feeling too warm or cold, numbness, swelling, hardness or pain.

What you must do?

Areas of red skin are an early warning sign that pressure, shear or friction are occurring. Usually by removing the cause the skin will recover. This is the most effective way to prevent skin damage.

REACT TO RED

If you find an area of redness that does not blanch:
Report to your Tissue Viability Link Champion or a senior member of staff


Effects of Pressure Ulcer Damage

Prevention is Better Than Cure

Keep Moving

K **Keep Moving**

Keep your residents moving

It is important to **AVOID** putting pressure on vulnerable areas or where pressure ulcers have formed. Moving and regularly changing position relieves the pressure allowing the blood supply to return reducing the risk of pressure damage and promoting wound healing.

What you must do?

If your resident is identified at RISK, you should commence a repositioning schedule which must state how often and in what way your resident needs repositioning.

TOP TIPS:
Make sure all of your team members are following the same repositioning schedule for each resident.

IMPORTANT
This will vary depending on your residents' skin inspection and their needs **NOT** by **RITUALISTIC** schedule (NICE, 2003).

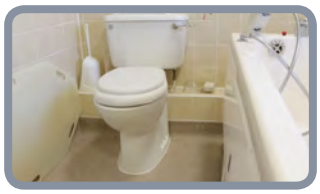
Examples of 'Keep Moving':

Moving feet

Transferring

Reclining

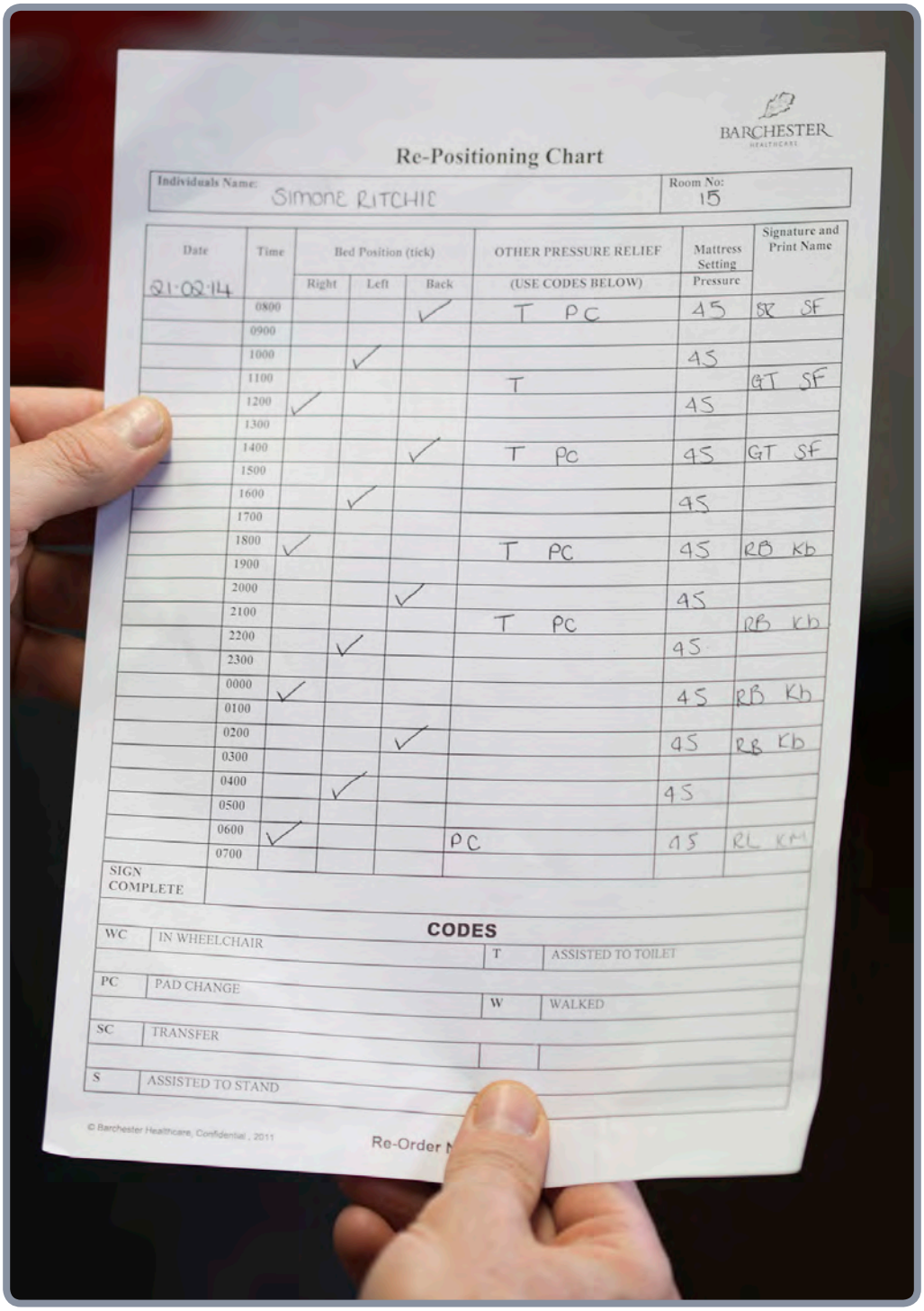
Encouraged to move independently



Regular toileting

Activity

Example of a good repositioning schedule



BARCHESTER HEALTHCARE

Re-Positioning Chart

Individuals Name:	Room No:
SIMONE RITCHIE	15

Date	Time	Bed Position (tick)			OTHER PRESSURE RELIEF	Mattress Setting	Signature and Print Name
		Right	Left	Back	(USE CODES BELOW)	Pressure	
21.02.14	0800			✓	T PC	45	SF SF
	0900						
	1000		✓			45	
	1100				T		GT SF
	1200	✓				45	
	1300						
	1400			✓	T PC	45	GT SF
	1500						
	1600		✓			45	
	1700						
	1800	✓			T PC	45	RB Kb
	1900						
	2000			✓		45	
	2100				T PC		RB Kb
	2200		✓			45	
	2300						
	0000	✓				45	RB Kb
	0100						
	0200			✓		45	RB Kb
	0300						
	0400		✓			45	
	0500						
	0600	✓			PC	45	RL KM
	0700						
SIGN COMPLETE							

CODES

WC	IN WHEELCHAIR	T	ASSISTED TO TOILET
PC	PAD CHANGE	W	WALKED
SC	TRANSFER		
S	ASSISTED TO STAND		

Re-Order

TOP TIPS:

- Use slide sheets to reduce friction and shear, do not leave them under your resident (each resident should have their own slide sheet)
- Manual handling devices should be used correctly
- Maintain an up to date and accurate repositioning chart
- Encourage residents who are able to move independently

Off loading heels

Keep heels free of pressure at all times.

30 degree tilt

Use the 30 degree tilt to ensure residents are kept off their sacrum and not directly on their hips.

The 30 degree tilt makes it easier for you to help residents with their diet and fluids. It also helps residents to comfortably engage in such activities as watching TV and conversing with visitors or staff.

It is good practice to use pillows to keep heels free of pressure.

Your residents need to be clean and dry

Moisture damage can occur to the skin by prolonged contact of moisture to the skin's surface. This can be in the form of sweat, wound leakage, urine and faeces. Urinary incontinence affects the pH of the skin making it more vulnerable. A combination of urine and faeces causes severe skin irritation that can quickly result in the skin breaking down. These factors will make the skin more vulnerable to pressure, friction and shear.

Moisture damage

Moisture damage can result in a moisture lesion developing. This is where the skin has become inflamed due to moisture. It will look red and sore and can be spread over a large area or found in creases and skin folds. The skin may be split in these areas. The skin may also be superficially broken.

What you must do to prevent moisture damage?

1. **Wash the area with pH friendly products.**
2. **Pat dry, DO NOT RUB, as this can damage the already fragile skin and be very painful.**
3. **Apply a prescribed barrier cream/film as directed.**

TOP TIPS:
Barrier Products
- Cream for protection
- Film for breaks

Water based products such as Cavilon soak into the skin and form a protective layer. This allows the moisture to be absorbed by a pad.

Oil based barrier products such as, Sudocream and Metanium, are not suitable for residents who wear pads!

WHY? - The oil sits on the pad and makes it less absorbent. This means the moisture stays next to the skin.

Things you can do

Make sure:

- all incontinent residents have had a continence assessment by an appropriate professional
- any changes in a resident's continence are reviewed and regularly assessed
- only the prescribed pads and pants are used and changed as necessary. Consider if the pad needs to be changed more often
- residents are offered the toilet or toileted regularly and ensure they are clean and dry
- the area is washed with warm water and only use pH friendly products as these do not dry the skin. Make sure you dry the area thoroughly
- any strong odours or colour changes to the urine are reported as this may indicate a urine infection and further action can be taken
- repeated loose stools are reported so further action can be taken
- any wet dressings, bandages or broken skin that is weeping are reported so further action can be taken
- any excess sweat/perspiration that may collect in skin folds and cause damage to the skin are reported. Keep these areas clean and dry to prevent damage

TOP TIPS:

- Just because your resident wears incontinence pads, does not mean they do not need toileting regularly
- Promoting regular toileting can prevent residents sitting in soiled pads for prolonged periods

Help residents have the right diet and plenty of fluids.

A healthy balanced nutritious diet that contains adequate amounts of protein and a good variety of vitamins can help prevent skin damage and promotes good wound healing. Residents that are malnourished, under weight or overweight, are at increased risk of developing pressure ulcers. Fluids keep our skin hydrated. Hydrated skin is less likely to breakdown.

Weight and Pressure Ulcer Risk

	Why a pressure ulcer risk?	
Overweight	**- May be less mobile - Have increased pressure**	**Consider bariatric equipment**
Underweight	**- No fatty tissue - Increasing bony prominences**	**Consider low weight settings**

- Is your resident underweight?
- Do they have loose fitting clothing or jewellery?
- Do they have loose fitting dentures?
- Do they have bony prominences?
- **If YES ask yourself why?**

Can't Eat	Won't Eat
Does your resident - have a poor appetite? **Is your resident** - not finishing meals? - not interested in food?	**Does your resident** - have difficulty eating? - leave food on the side? - spit food out? - cough and splutter? - store food in their mouth?
Possible Causes	**Possible Reasons**
Nausea Constipation Illness Pain Depression	Can't reach their food Can't swallow Not in a comfortable position Can't feed themselves Dislike the food on offer

What you MUST do?

1. Report to a senior member of staff or your Tissue Viability Link Champion

They may complete a Malnutrition Universal Screening Tool score (MUST) and if needed refer to an appropriate health professional to treat underlying causes. For example:

- Dietician
- GP
- Speech and language therapy team

For further information:

Refer to your area prescribing guidelines for detailed guidance on monitoring or supplement provision.

Visit the British Association for Parental and Enteral Nutrition (BAPEN) website for guidance on Malnutrition Universal Screening Tool (MUST) - www.bapen.org.uk

2. Monitor by keeping accurate food diaries

Food and Fluid Chart Records

Individuals Name: Sally | Today's Date: 01-01-14 | Room No: 1

MEALS OR SNACKS	Description & Quantity offered e.g Slice of bread etc	Quantity Eaten						Record of Fluid Intake & Output			Reason for poor intake (any alternatives offered?)
	FOOD DESCRIPTION	None	Tsp	1/4	1/2	3/4	All	TIME	Fluid Input (mls)	Fluid Output	COMMENTS
BREAKFAST Time:	one bowl of porridge						✓	0800	250		Signed:
								0900			
								1000	100		
								1100	250		
								1200			
During the morning								1300	250		Signed:
								1400			
LUNCH Time:	Shepherds pie					✓		1500	250		
	mash potato						✓	1600			
	carrots						✓	1700	250		
	peas						✓	1800			Signed:
	cabbage and gravy						✓	1900	100		
During the afternoon	fruit and cream					✓		2000	250		
								2100			Signed:
TEA Time:	vegtable soup				✓			2200			
	slice of white bread						✓	2300			
								0000			
	strawberry yogurt						✓	0100			Signed:
SUPPER Time:								0200			
	x2 digestive biscuits						✓	0300			
								0400			
								0500			Signed:
NIGHT								0600			
								0700			
								TOTALS	1700		Signed:

Signed complete: L Taylor (Night Carer or RGN sign to say it is completed)

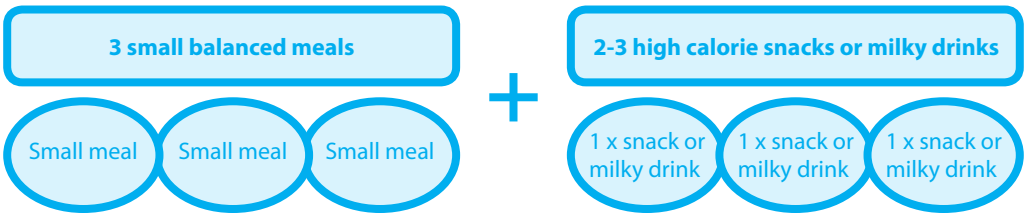
3. Weigh your resident

Weigh your resident weekly, if appropriate, to monitor weight loss or weight gain (if a resident is in the end stages of life and it would be detrimental to their emotional wellbeing to identify weight loss that cannot be managed. This will need to be discussed with your manager).

Things you CAN do

Offer little but often!

Smaller meals regularly with regular snacks will be easier for your resident to manage and support them to build up their appetite gradually. **Encourage the following each day:**



Adding extra nourishment:

Fortified milk: mix 2 tablespoons of milk powder into half a pint of full cream milk.
Use this fortified milk in place of ordinary milk or water to make up coffee, packet soup, condensed soup, sauces, mousses, milk puddings, porridge and other breakfast cereals.

- **Breakfast cereals: add one or more of the following:**
  Fortified or evaporated milk, cream, thick and creamy yoghurt, fresh or dried fruit, nuts, syrup, honey or sugar. If you have diabetes, please ask your dietician or diabetes healthcare team before adding extra sugar, syrup and honey to food and drink.

- **Soups and sauces: add one or more of the following:**
  Grated or cream cheese, cream, milk powder, fortified or evaporated milk, crème fraîche, thick and creamy yoghurt, fried onions, margarine, butter, croutons, lentils or pasta.

- **Potatoes and vegetables:**
  Roasting potatoes and vegetables in olive, rapeseed or sunflower oil will provide more energy than boiling them. Or add one or more of the following to potatoes or vegetables; grated cheese, cream, milk based sauces, margarine, butter, mayonnaise, salad cream or fried onions.

- **Puddings and cakes: add one or more of the following:**
  Cream, evaporated milk, crème fraîche, thick and creamy yoghurt, custard, ice-cream, jam, honey, syrup, treacle, chocolate or fruit sauces, dried fruit. If your resident has diabetes, please discuss with the healthcare team before adding extra sugar, jam, syrup, treacle, honey and chocolate or fruit sauces to food and drink.

TOP TIPS:
- Offer supplements after or between meals
- Taste better chilled
- Some can be frozen to make ice-cream
- Supplements can be warmed but not boiled
- Can be used in cooking
- Can be added to other foods to disguise taste, ie porridge, mashed potatoes

Supplements

These do not replace dietary intake. They should be used in conjunction with an ordinary diet to help increase your resident's appetite over a period of time. They are prescribed and come in a large variety of flavours and are available through their GP. Supplements come in a variety of styles such as milk or yoghurt, juice, savoury, desserts and powder.

Conclusion & Acknowledgments

This Teaching Pack and DVD have been designed to support pressure ulcer prevention awareness for carers who work in all social care and healthcare settings. By watching the DVD, completing the questionnaire and using the information pack as a resource, staff should feel more equipped to implement prevention measures and know what to do if they find any pressure damage.

Pressure ulcers are monitored by governing bodies and classed as harm which, in some circumstances, will be investigated. The harm caused by pressure is in the main preventable and as care providers we have a duty of care to recognise this and then assess and implement measures to prevent it.

It is the responsibility of the manager to ensure that staff are educated and to monitor their development and skills. This pack aims to support this process and starts by explaining the facts and risk factors and how pressure ulcers can develop, the impact of pressure ulcers on residents and staff, how to risk assess and prevent damage occurring. It includes equipment flow charts, stages of pressure damage and examples of good practice.

Once the questionnaires have been completed they will need to be reviewed by the Tissue Viability Link Champion or 'identified lead' to sign off the staff member as competent in pressure ulcer prevention.

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