ELHT Pressure Ulcer Change Package
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Introduction

The Pressure Ulcer Collaborative (PUC) began in April 2014. Teams from across ward areas and the community nursing teams were invited to work together with the aim to:

- Reduce grade 2 hospital and community acquired pressure ulcers by 15%
- Eliminate grade 3 and 4 hospital and community acquired pressure ulcers

As of 30th April 2015 the collaborative had achieved:

- Total elimination of grade 2 hospital acquired pressure ulcers in pilot ward areas
- Total elimination of acquired grade 3 and 4 pressure ulcers in all pilot areas
- The development of a specific Care Home support and training package by the district nursing teams of Accrington and Clayton, Kiddrow Lane and St Peter’s Centre areas to develop relationships of care with care home staff and managers.
- ‘Time for Turn’ resource- highlighting the time for turning individuals at risk of Pressure Ulcers.

This change package introduces the changes that teams have tested and implemented in their work areas to reduce the number of pressure ulcers acquired by patients whilst in their care.

Key Contacts:

Tissue viability nurse extension 82349

Thank-you for your valuable work

The Pressure Ulcer Collaborative Steering Group
<table>
<thead>
<tr>
<th><strong>Summary of all the interventions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time to Turn</strong></td>
</tr>
<tr>
<td><strong>Pressure relieving Equipment Flow chart prevent</strong></td>
</tr>
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<td><strong>Pressure Ulcer Prevention Implementation Lead (PUPIL)</strong></td>
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<td><strong>React to Red Skin</strong></td>
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<td><strong>Patient information</strong></td>
</tr>
<tr>
<td><strong>STOP, THINK, PRESSURE Poster</strong></td>
</tr>
</tbody>
</table>
Time to turn

The time to turn triangle needs to be placed above all patients’ beds or on side room door of those that have been identified at risk of pressure damage from their water low score. The staff can write what time the next turn is due then all staff are aware when the patient needs repositioning.

Nursing staff at all levels are responsible to ensure a consistent turning of at risk patients.

Pressure Relieving Equipment Flow Chart

The flowchart is for assessing at risk patients for pressure ulcer preventing equipment and to help all nursing staff to ensure correct equipment is selected.

All staff must be aware of all devices that cause skin damage and how to prevent.
PRESSURE REDUCING PRODUCTS

Is your patient at risk of device related pressure damage?

Yes

Indications for use

No

Continue skin inspections as Trust policy

Is your patient immobile and unable to reposition themselves?

Yes

With the patient and carers discuss the importance of pressure ulcer prevention, methods of doing this, observing and caring for the skin and reporting any changes. Give the Trust Pressure Ulcer Prevention information leaflet

Appearance of skin over bony prominences or at edges of casts and other vulnerable areas

Intact

Healthy skin.
No marking

Skin inspections as Trust guidance. Follow Pressure Ulcer Guidelines

Intact

Red Non-Blanching erythema
Blanching erythema
Recently healed Pressure Ulcer.

Consent from patient

Not intact

Grade damage and refer according to Trust policy
Complete IR1
Dress wound according to wound care guidelines

Devices that can cause Pressure damage where Gel pads can help:-

Oxygen masks
Nasal Cannula
CPAP masks
Splints
Casts
Slings

Device related - Options

Heal Protectors
Foam pads
Referral to podiatry as criteria

Heels

Increase frequency of repositioning
Consider different device
Silicone tape / dressing
Use gel pad / strip
Remove gel pad daily to allow skin to be cleansed and inspected. Important to prevent maceration.

Off Loading devices include:-
Pillows,
Devon boots / foam pads,
Heel Pro,
Custom made casts,
Podus boots
The Pressure Ulcer Prevention Implementation Lead (PUPIL), link nurse acts a resource and trainer within clinical areas and understands prevention of pressure ulcers and how to optimise core goals. The lead must keep all relevant training information up to date and share new ideas and best practise. The lead will cascade training and support other work relating to prevention and management of skin care.

If you are unsure who the link nurse is on your ward please ask the ward manager.

React to Red

This workbook will enable you to undertake pressure area care for individuals, following the individual’s care plan and risk assessment, as well as relevant protocols and procedures within your work area. The aim is to maintain healthy skin and thus prevent breakdown and the development of pressure sores. This can be done in groups or buddy up with a colleague.

You will learn the 5 elements of care that can be bundled together to prevent pressure ulcers developing.

- SSKIN:
  - Surface
  - Skin Inspection
  - Keep Moving
  - Incontinence
  - Nutrition

Prevention of heel damage

This is an advice tool to help nursing staff identify tissue damage to heels and what immediate actions should be taken. This should be placed in an area where all staff can refer to the tool.
<table>
<thead>
<tr>
<th>Tissue Damage to Heel</th>
<th>Immediate actions (Discuss these with patients +/- carers)</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>No damage High risk</td>
<td>Ensure all staff aware patient is at risk. Those with reduced mobility. <strong>Off-load</strong> if in bed for prolonged periods. Ensure good skin care. Assess skin for changes and <strong>REACT TO RED</strong>, document skin assessments and interventions if there are any changes.</td>
<td>None required.</td>
</tr>
<tr>
<td>Redness (Erythema)</td>
<td><strong>Off-load</strong> when in bed. Ensure feet not resting on heels when sitting in chair. Maintain good skin care. Assess skin for changes, document findings and interventions</td>
<td>None required</td>
</tr>
</tbody>
</table>
| Discolouration (Deep Tissue Injury)      | **Complete incident report**  
**Off-load** when in bed. Ensure feet not resting on heels when sitting in chair. Maintain good skin care. Assess skin for changes, document findings and interventions | In hospital: Tissue Viability                 |
| Where wound present                      | **Complete incident report**  
**Off-load** when in bed. Ensure feet not resting on heels when sitting in chair. Undertake immediate actions for wound management. Refer for specialist advice | In hospital: Tissue Viability  
If patient has diabetes refer to Diabetic Foot Team  
- RBH patients only  
Community –  
Refer to Podiatry for sharp debridement and off-loading  
If infection present liaise with GP |
| Blister                                  | **Wound management:**  
De-roof blister  
Apply foam dressing, initially change daily so wound can be assessed for deterioration  
Follow specialist management plan when available. |                                              |
| Full thickness tissue damage              | **Wound management:**  
Swab if any signs of infection. Apply alginate and absorbent dressing, initially change daily so wound can be assessed for deterioration  
Follow specialist management plan when available. |                                              |
| Dry Necrosis                             | **Wound management:**  
Refer to Vascular Service for arterial assessment.  
Apply foam dressing, **DO NOT USE PRODUCTS TO HYDRATE WOUND**, initially change daily so wound can be assessed for deterioration and signs of infection.  
Follow specialist management plan when available. |                                              |
Moisture or Pressure Tool

This is an education leaflet to help staff identify the difference between pressure damage and moisture damage looking at signs and symptoms, how to manage this tissue damage and how to report damage if necessary.

Patient Information for prevention and management of Pressure and moisture damage

This is a patient and carer information leaflet to educate on the cause of pressure damage, how to prevent and who to contact if any concerns. On admission patients should be offered this leaflet.

STOP, THINK, PRESSURE Poster

This poster is for patient waiting areas, clinics, dayrooms and discharge lounges to help educate patients, carers and visitors to stop and think about pressure damage and to let staff know of any concerns they might have in relations to pressure damage.
### Management

<table>
<thead>
<tr>
<th>Moisture Lesion</th>
<th>Pressure Ulcer</th>
<th>Combination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wash gently with a low pH soap or a skin cleanser</td>
<td>Think SSKINS: Surface (bed, chair) Skin inspection Keep moving Incontinence Nutrition (food, hydration)</td>
<td>Bring the two management plans together Focus on pressure and moisture management</td>
</tr>
<tr>
<td>Dry thoroughly by patting the skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilise barrier protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide patient information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reporting

<table>
<thead>
<tr>
<th>Moisture Lesion</th>
<th>Pressure Ulcer</th>
<th>Combination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not to be reported as a Serious Incident</td>
<td>Report all 2,3 and 4 pressure ulcers on the Trusts reporting system - Dazzle</td>
<td>Report all combination wounds as pressure ulcers</td>
</tr>
<tr>
<td>Does not require a Root Cause Analysis</td>
<td>Use Debrisoft® to assist with categorisation</td>
<td></td>
</tr>
<tr>
<td>Refer for Specialist Tissue Viability/Incontinence Team if advice is required</td>
<td>Consider referral of category 3 and 4 to Tissue Viability for advice.</td>
<td></td>
</tr>
</tbody>
</table>

### Combination

- A moisture lesion and a pressure ulcer may exist in the same area
- Where incontinence associated dermatitis/moisture lesions are accompanied by pressure, this must be reported as a pressure ulcer
- The two areas of moisture and pressure need to be addressed as part of their care plan

This ‘Moisture Lesion or Pressure Ulcer?’ tool is the work of the Worcester Tissue Viability teams, presented by Jackie Stephen-Haynes at EWMA 2015, London.

### Tissue Viability Link

For further information on how you and your colleagues can use this tool, please contact:

**Tissue Viability Link**

*For more information on Debrisoft® please call: Sharon Taylor: 07896 279 961 email: sharon.taylor@activahealthcare.co.uk or visit: www.debrisoft.co.uk

**References:**

This leaflet has been reproduced with kind permission from Worcester Tissue Viability Team.
<table>
<thead>
<tr>
<th>Incontinence Associated Dermatitis (IAD) (Moisture Lesions)</th>
<th>Tick box if present</th>
<th>Signs and Symptoms</th>
<th>Tick box if present</th>
<th>Pressure Ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Moisture must be present (e.g., shiny, wet skin caused by urinary incontinence or diarrhoea)</td>
<td>☐</td>
<td>&lt; Cause &gt;</td>
<td>☐</td>
<td>• Pressure present</td>
</tr>
<tr>
<td>• Natal cleft/inner gluteal/buttocks/any skin fold</td>
<td>☐</td>
<td>&lt; Location &gt;</td>
<td>☐</td>
<td>• Over a bony prominence or aligned with causative pressure</td>
</tr>
<tr>
<td>• IAD may occur over a bony prominence. (If this appears to be the case, exclude pressure shear and friction prior to diagnosis)</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mirror image and linear in shape (splits in skin)</td>
<td>☐</td>
<td>&lt; Shape &gt;</td>
<td>☐</td>
<td>• Takes the appearance of the causative pressure</td>
</tr>
<tr>
<td>• Diffuse, in several superficial spots</td>
<td>☐</td>
<td></td>
<td></td>
<td>• Limited to one spot or specific area</td>
</tr>
<tr>
<td>• Superficial</td>
<td>☐</td>
<td>&lt; Depth &gt;</td>
<td>☐</td>
<td>• Superficial or deep</td>
</tr>
<tr>
<td>• No necrosis</td>
<td>☐</td>
<td>&lt; Necrosis &gt;</td>
<td>☐</td>
<td>• A black necrotic scab on a bony prominence</td>
</tr>
<tr>
<td>• Diffuse or irregular edges</td>
<td>☐</td>
<td>&lt; Edges &gt;</td>
<td>☐</td>
<td>• Distinct edges</td>
</tr>
<tr>
<td>• Non uniform redness</td>
<td>☐</td>
<td>&lt; Colour &gt;</td>
<td>☐</td>
<td>• Uniform redness</td>
</tr>
<tr>
<td>• Blanchable or non-blanchable erythema</td>
<td></td>
<td></td>
<td></td>
<td>• If redness is non-blanchable, this indicates damage to the capillaries</td>
</tr>
<tr>
<td>• Pink or white surrounding skin due to maceration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Remember:** Moisture damage will improve rapidly (e.g. 48-72 hrs). Pressure Ulcers will improve more slowly (e.g. usually longer than 7 days). If the area occurs over a bony prominence it is more likely to be a Pressure Ulcer.
What are pressure ulcers?

Pressure ulcers are areas of damage to the skin and underlying tissue. They are also known as pressure sores or bed sores. Pressure ulcers can develop quickly. Therefore it is important to recognise the early signs of damage to prevent them developing. Pressure ulcers can be very serious and in extreme cases can become life-threatening if they become infected.

What causes pressure ulcers?

Pressure ulcers are caused by normal body weight that squashes the skin and damages blood supply.

Who is at risk?

Anyone can get a pressure ulcer but certain people are more at risk. These include people who have a serious illness; reduced mobility such as a stroke; spinal injury or a plaster cast. People can also be at risk from poor or reduced diet, weight problems, poor posture or unsuitable equipment.
You are more likely to get a pressure ulcer if you:

- Have to stay in bed
- Are in a wheelchair
- Spend long periods in an armchair
- Have difficulty moving about
- Have a lot of pressure applied to any area of your body such as tight shoes
- Are elderly or frail
- Have a serious illness or are undergoing surgery
- Are incontinent
- Have reduced ‘feeling’ in a part of your body
- Are not eating a well balanced diet, are overweight or not taking adequate fluids
- Are not sitting properly in a chair

Assessing your risk

A member of the health care team looking after you will examine your skin and ask certain questions. This is called a ‘risk assessment’. If you (or your carer) are aware of a risk, you should inform the staff looking after you as soon as possible.

As part of your treatment plan, your care team will discuss with you the best way to prevent pressure ulcers. This will be based on your individual circumstances.

![Diagram showing different positions for assessing risk]

Usually the effects of pressure can be relieved by people moving around, changing position and adjusting clothing and bedding. If you are unable to do this, you may be at increased risk of developing pressure ulcers.
What can I do to avoid getting a pressure ulcer?

The best way to avoid an ulcer is to move around as much as possible.

If you are a smoker, giving up is one of the most effective ways of preventing pressure ulcers. Smoking reduces the levels of oxygen in your blood. It also weakens your immune system, which increases your risk of developing pressure ulcers.

If you have problems with movement you will need frequent position changes

If you are not able to move by yourself, then you will need help to change your position at least every two hours.

Problems with sensitivity to pain or discomfort

If you are in an armchair or wheelchair and are unable to walk or stand, try to take the weight off your bottom every 15 minutes. Also, try to take the weight off your heels every 15 minutes. Ankle and foot exercises will help with circulation. Some conditions, such as diabetes, stroke and some treatments such as epidural pain relief, may reduce your sensitivity to pain or discomfort so you are not aware of the need to move.

IF YOU ARE WORRIED YOU MAY BE AT RISK OF PRESSURE DAMAGE OR SUSPECT YOU MAY HAVE SOME PRESSURE DAMAGE, CONTACT YOUR NURSE OR DOCTOR FOR ADVICE.

Check your skin for signs of damage at least once a day

Look for skin that doesn’t return to normal colour after you have taken the weight off it. For areas that are hard to see, use a mirror or ask someone to look for you. Never lie on skin that is redder or darker than usual. Wait until it has returned to its normal colour. Check for blisters, dry cracked areas or shiny patches. Good personal hygiene and care of your skin is essential in preventing damage.

Eat a well balanced diet

Try to have 3 meals per day with enough protein and calories to maintain a healthy weight. Drink plenty of water i.e. a minimum of 8 - 10 cups per day and to ensure a balance of good health, have 5 portions of fruit and vegetables per day.

Following assessment, you may need to be referred to a dietitian.

Where can I obtain further information?

You can ask your nurse or doctor for information on the prevention of pressure ulcers.
For more information about Community Services or if you have a comment about this publication please contact us as below.

If you would like this leaflet translating or in another format please contact:-

<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bengali</td>
<td>যদি আপনি এই লিফলেট অনুবাদ বা অন্য আকার পত্রে চান তাহলে নিচে তুলনা করুন।</td>
</tr>
<tr>
<td>Polish</td>
<td>Prosimy o kontakt, jeżeli pragnie Państwo otrzymać niniejszą ulotkę w innym języku lub formacie:</td>
</tr>
</tbody>
</table>

For further information please contact your nursing team or GP practice nurse.
Customer Information Line: Tel: 01282 803521
Or alternatively email your queries:
communitydivision@elht.nhs.uk

Safe | Personal | Effective

Community Services
East Lancashire Hospitals NHS Trust
Casterton Avenue
Burnley Lancashire
BB10 2PQ
STOP...  THINK...  PRESSURE

Patients, please.......  

Tell us – if you are not moving as much as you used to.

Tell us – if you’re not eating as much as you used to.

Tell us – if you have a sore bottom or hips, heels, elbows.

Tell us – if you sleep in a chair rather than your bed.

Tell us – if you are having continence problems.

Tell us – if you have reduced feeling in your feet.

Tell us – if you have had a pressure ulcer before.

KEEP MOVING

INSPECT SKIN

PREVENT FRICTION

Seek help at the earliest sign of skin deterioration.