

Care home pressure ulcer quick reference guide

Pressure Ulcer Definition

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 skin or an open ulcer and may be painful”.

NHS Improvements (2018)

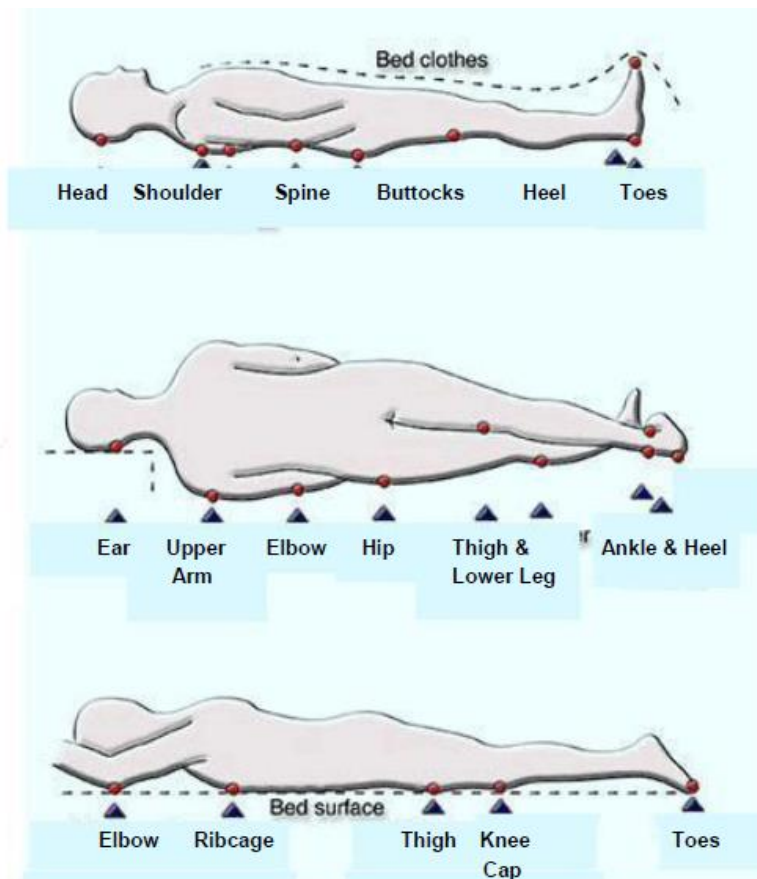


Skin inspections

Early identification of skin changes is essential in the prevention of pressure ulcer development and deterioration, and regular skin inspection is a core element of the SSKIN bundle.

Pressure ulcers are caused by a combination of:

- Pressure from the weight of the body pressing against a hard surface, damaging the blood supply that keeps the skin healthy
- Shearing – this may occur if patients slide down, or are dragged up the bed or chair causing damage to the deeper layers of the skin



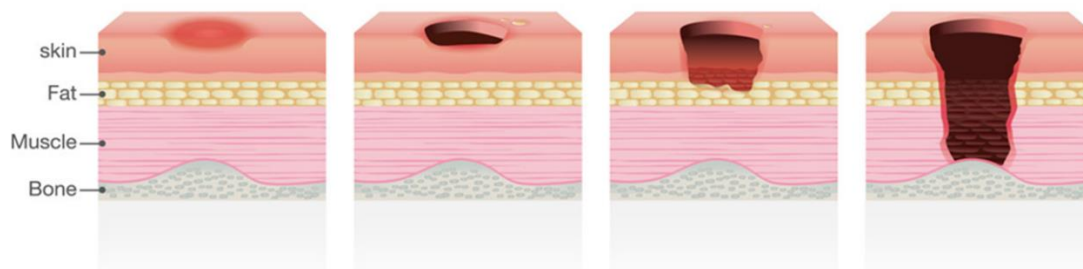
Early symptoms

Early symptoms of a pressure ulcer include:

- Part of the skin becoming discoloured, people with pale skin tend to get red patches, while people with dark skin tend to get purple or blue patches
- Discoloured patches not turning white when pressed
- A patch of skin that feels warm, spongy, or hard
- Pain or itchiness in the affected area

Later symptoms include:

- An open ulcer or blister
- A deep ulcer that reaches the deeper layers of the skin
- A very deep ulcer that may reach muscle, bone or tendon



Who is at risk?

Anyone can get a pressure ulcer, but the following things can make this more likely to happen:

- Extremes of age, especially being over 70
- Reduced mobility, being confined to bed
- Inability to move parts of the body
- Incontinence
- Poor diet and fluid intake, obesity or under being weight
- Medical conditions that affect blood supply, make skin more fragile or cause movement problems

If you are looking after someone either in a care setting or their own home and you identify any early skin changes, it is important that you take action to prevent further deterioration.

You **MUST** take the following action:

- Offload the area using the techniques below
- Increase the frequency of repositioning and ensure this is clearly documented
- Ensure all moving and handling techniques are reducing the risk of shearing forces, use full length slide sheets
- Ensure bedding is crease free, clothing does not have thick seams and footwear is well fitting
- Inform the senior member on duty and refer to the DN Team for support and reassessment/equipment review

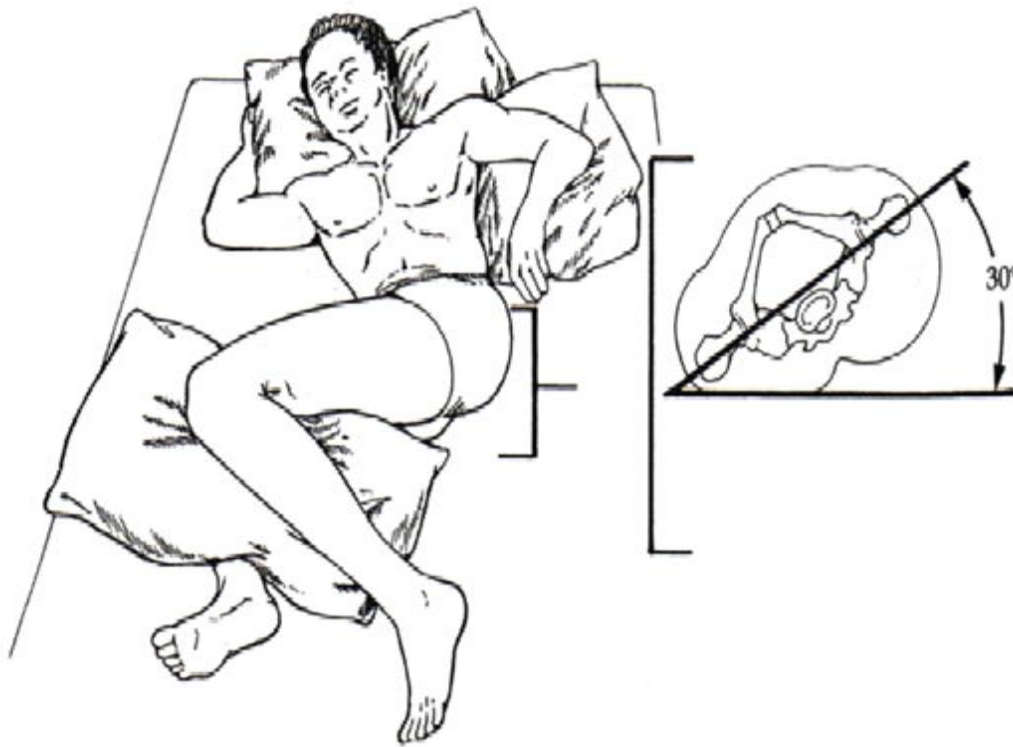
You **MUST** get medical advice immediately if:

- There is red, hot, swollen skin
- Pus leaking from the pressure ulcer
- Severe or worsening pain
- A high temperature

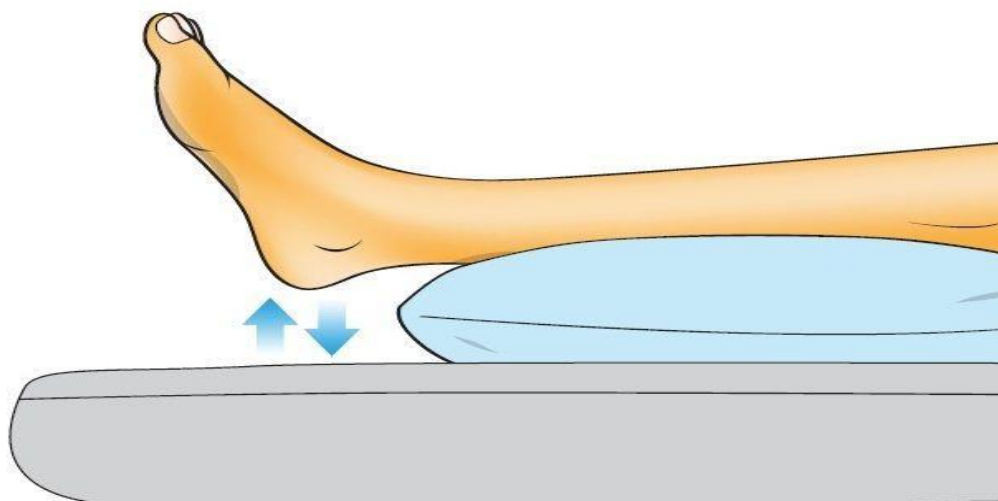
These symptoms could indicate that there is a serious infection that needs treatment

Offloading Techniques

30-degree tilt



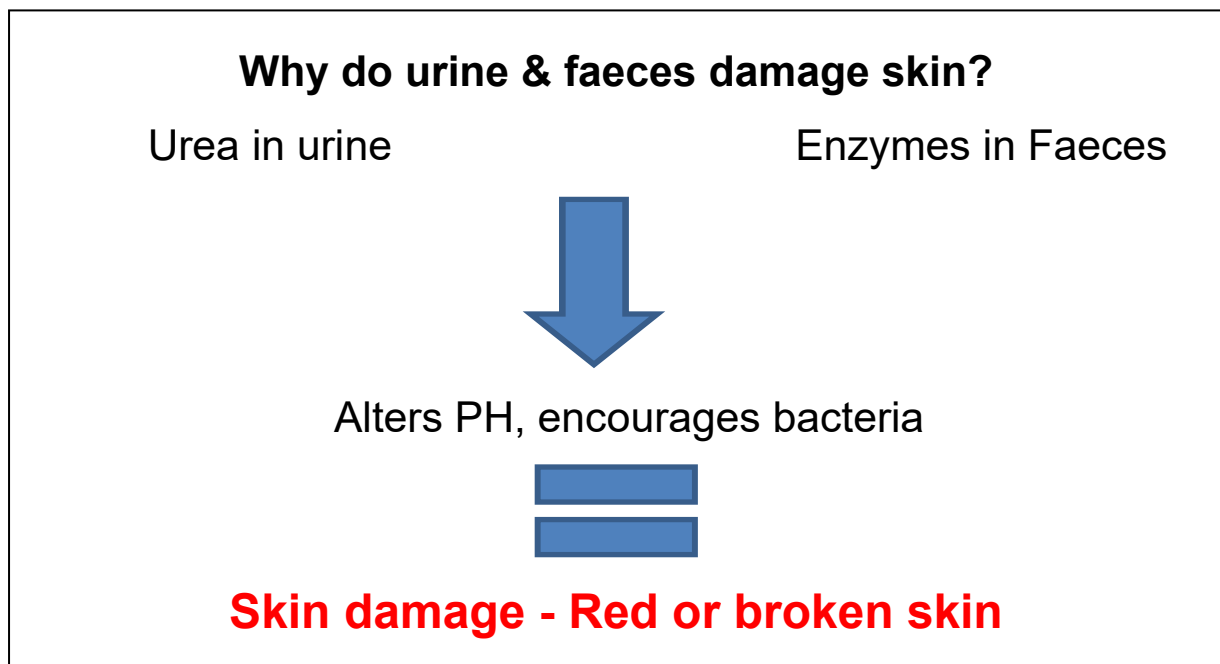
Offloading



Incontinence and moisture

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 & faeces.

These factors will make the skin more vulnerable to pressure, friction & shear.



Aim to keep the skin clean, dry, and moisturised

- Cleanse skin regularly/avoid soap
- Appropriate use of continence products
- Regularly apply moisturiser/barrier cream
- Evaluate skin condition at each contact

Tissue Viability Training

Virtual training accessible to all care homes via Microsoft Teams

1st Dressings and React to Red

Daily sessions available Monday -Friday, evening, and early morning sessions also available to allow all staff to access

1st dressings training supports with upskilling carers to deliver first aid to any resident who presents with a skin tear, in the form of applying the first dressing. The training is evidence based and competency assessed. Dressing provision is supplied and replenished by your DN team for any resident in a residential bed on successful completion of the training. Dressing use is monitored for audit purposes. The training covers skin integrity, anatomy and physiology and best practice guidance for skin tear management supported by the skin tear protocol, details of protocol requirements and supporting documentation will be supplied.

React to Red training supports knowledge around all aspects of pressure ulcer prevention, including patient assessment and how to identify those most at risk, early detection of skin changes, offloading techniques to prevent deterioration and the correct use of pressure relieving equipment.

All requests to access 1st Dressings and React 2 Red training sessions should be by return of email to pressureulcerteam@bdct.nhs.uk

Stop Pressure Ulcer Word Search

Z V D E W Z F T T W S T V H D J Z E P Z S Q P P C
M A T T R E S S N K K N O I T A R D Y H Z R B Z F
D S B G P Y P T I E A E V Q O B O Z A L E R G R A
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SKIN
BLANCHING
MAELOR
CHAIR
ERYTHEMA
FRICTION
GIVEINFORMATION
HEELPROTECTOR
HOIST
HYDRATION
INCONTINENCE
KEEPMOVING

MOISTURE
MATTRESS
MUST
NUTRITION
PRESSURE
PRESSUREULCER
RISKASSESSMENT
SHEAR
SKIN
SLIDESHEET
SURFACE
WATERLOW