**INTRODUCTION**

- Pressure damage prevention Training is now essential in Oxford Health.
- Cost of pressure damage to
- the patient-incidence
- Burden to the NHS £1.4- £2.1 Billion
- Are pressure Ulcers Avoidable?
MEET ALAN
Alan

- Is a 79 year old man who has been admitted into your team.
- He has been discharged home from hospital were he lives with wife who is frail but able.
- He has a very caring extended family.
- Please see his discharge letter which was sent from the hospital.
Dear colleagues,

Thank you for taking this pleasant man into your team Alan is a complete sweetie! He was admitted to us 4 weeks ago unresponsive following a CVA with a right sided weakness he has recovered well after intensive rehab.

He has a past medical history of –
- Hypertension
- AF
- Urinary incontinence
- Falls
- Cataracts
- Hiatus Hernia

Medication he has been discharged on is –
- Nifedipine 10mg
- Digoxin 62.5mcg
- Warfarin as dosed
- Paracetmol 1g

He has been discharged with 3 times a day care from the fairy Dreadful care agency

Regards

Utter Useless
Ward Manager
WHAT ARE ALAN’S RISKS?

- Previous Pressure Damage
- Immobility/ poor mobility
- Positioning and Posture
- Care environment
- Medical Devices/ Equipment
- Cognitive/psychosocial considerations
- Acute/Chronic/End of Life Illness
- Manual Handling Techniques
- Clothing
- Surgery
Guide identification of people at risk of pressure ulcer development

Guide preventative measure implementation

Provide a source of documentation

To be undertaken within 6-8 hours of admission/first visit along with full skin inspection

To be repeated when clinical condition changes or at regular intervals if patient stable

To be used along side clinical judgement
To promote uniformity in risk assessment - so primary and secondary care are speaking the same language. (There are currently 7 risk assessments in circulation in OUH). Also, this is in preparation for transfer to EPR system OUH.

Braden is less subjective - proven to provide high inter-rater reliability and consistency of patient risk assessment.

Recommended by NICE - Braden is the most validated and reliable risk assessment tool.
A BIT ABOUT THE BRADEN SCALE...

- Developed 1984 by Braden and Bergstrom

- Six elements that contribute to either higher intensity and duration of pressure or lower tissue tolerance to pressure therefore increasing the risk of pressure ulcer development.
  
  - Sensory perception
  - Mobility (ability to change own position)
  - Nutrition
  - Moisture
  - Friction and shear
  - Activity

- Each item is scored between 1 and 4 guided by a descriptor, except Friction and Shear which is scored 1 to 3.

- The lower the score, the greater the risk.

  15 + = low risk
  13-14 = moderate risk
  12 or less = high risk
  Below 9 = severe risk

- Limitations: Does not consider pre-existing or previous pressure ulceration
The lower the score, the greater the risk.

This is the opposite way round to the Walsall.

A score of 9 and below is now Severe risk.
## Example of Braden

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>Moisture</th>
<th>Activity</th>
<th>Mobility</th>
<th>Nutrition</th>
<th>Friction and Shear</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Impairment</td>
<td>Rarely Moist</td>
<td>Walks Frequently</td>
<td>No Limitations</td>
<td>Excellent</td>
<td>4</td>
</tr>
<tr>
<td>Slightly Limited</td>
<td>Occasionally Moist</td>
<td>Walks Occasionally</td>
<td>Slightly Limited</td>
<td>Adequate</td>
<td>3</td>
</tr>
<tr>
<td>Very Limited</td>
<td>Very Moist</td>
<td>Chair bound</td>
<td>Very Limited</td>
<td>Probably Inadequate</td>
<td>2</td>
</tr>
<tr>
<td>Completely Limited</td>
<td>Constantly Moist</td>
<td>Bedbound</td>
<td>Completely Immobile</td>
<td>Very Poor</td>
<td>1</td>
</tr>
</tbody>
</table>
### Sensory Perception

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unresponsive (does not moan, flinch or gasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.</td>
<td>Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness</td>
<td>Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities</td>
<td>Responds to verbal commands. Had no sensory deficit which would limit ability to feel or voice pain or discomfort.</td>
</tr>
</tbody>
</table>
| Degree to which skin is exposed to moisture | 1. Constantly Moist  
Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. | 2. Very Moist  
Skin is often, but not always moist. Linen must be changed at least once a shift. | 3. Occasionally Moist  
Skin is occasionally moist, requiring an extra linen change approximately once a day. | 4. Rarely Moist  
Skin is usually dry. Linen only requires changing at routine intervals. |
| Degree of physical activity | 1. Bedfast  
Confined to bed. | 2. Chairfast  
Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. | 3. Walks Occasionally  
Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. | 4. Walks Frequently  
Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours. |
| Ability to change and control body position | 1. Completely Immobile
Does not make even slight changes in body or extremity position without assistance. | 2. Very Limited
Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. | 3. Slightly Limited
Makes frequent though slight changes in body or extremity position independently. | 4. No Limitations
Makes major and frequent changes in position without assistance. |
## Usual food intake pattern

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Very Poor</strong></td>
<td>Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NBM and/or maintained or clear liquids or IVs for more than 5 days.</td>
</tr>
<tr>
<td><strong>2. Probably Inadequate</strong></td>
<td>Rarely eats a complete meal and generally eats only about ½ of any food offered. Eats only 3 servings of protein per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.</td>
</tr>
<tr>
<td><strong>3. Adequate</strong></td>
<td>Eats over half of most meals. Eats a total of 4 servings of protein each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.</td>
</tr>
<tr>
<td><strong>4. Excellent</strong></td>
<td>Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of protein per day. Occasionally eats between meals. Does not require supplementation.</td>
</tr>
</tbody>
</table>
## Friction and Shear

<table>
<thead>
<tr>
<th>Friction and Shear</th>
<th>1. Problem</th>
<th>2. Potential Problem</th>
<th>3. No apparent problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.</td>
<td>Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets or other surfaces. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.</td>
<td>Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.</td>
</tr>
</tbody>
</table>
Risk assessments are tools - they must be supported by clinical judgement.

You cannot adapt this tool.

Current or previous pressure damage - how does this effect the risk score?

Availability of associated documents.

We went Live on the 3rd of November 2014. Walsall should no longer be used in practice.
**RISK ASSESSED...WHAT NOW?**

- Ensure risk assessment fully documented along with full skin inspection.

- Implement preventative measures according to identified risk - and document these interventions.

- Regularly evaluate effectiveness of interventions.

- Provide patient and relative education regarding pressure ulcer prevention- not just the leaflet.

- Ensure degree of risk fully communicated with next clinical area - enable time to get equipment in place for at risk patients.
PRESSURE DAMAGE
There are 3 different ways in which damage can occur:

- Direct pressure
- Shear
- Friction
WHAT IS A PRESSURE ULCER?

“An area of localised damage to the skin and underlying tissue caused by pressure, shear, friction and/or a combination of these.”

EPUAP(1999)
LOWER LIMB ASSESSMENT

In line with NICE guidelines (CG29, Pressure Ulcers: The management of Pressure Ulcers in Primary & Secondary Care and CG147, Lower limb Peripheral Arterial Disease: Diagnosis & Management).

- Ankle movement
- Temperature
- Colour
- Doppler
- Oedema
- pain/sensation
- condition of skin
- Capillary refill
“A short period of vascular occlusion is followed by a period of increased blood flow through the tissues which had been ischaemic. This increased blood flow after occlusion is called reactive hyperaemia.”

Michel and Gillot (1990)
Take your gloves off!
- Temperature - warm/cold
- Induration
- Oedema
- Turgor
- Moisture
Skin assessment
So what are you looking at?

- Skin should be observed in good lighting.
- Use a long handled mirror.
- Skin- reddened areas, non-blanching erythema.
- Colour
- Dark pigmented skin - purplish/bluish

Appearance
- Skin disease?
- Nodular?
- Excoriation?
- Maceration?
- Flaky?
- Bruised?
- Ecchymosis?
- Any breaks? -fragile skin

- Full body inspection
- Check under skin folds
- Areas of pain
- Discuss with patient
- Examine skin after equipment removal e.g. O2 tubing
Does your patient have a continence problem?
Is Your patient excessively sweaty or moist?
Do they have lots of skinfolds?
Do they have a moisture lesion?
Management plan.
Ongoing review of the management plan.
Moisture present
Irregular edges/in a line
Intragluteal/may be over bony prominences
Copy lesions/Butterfly pattern
Superficial
No necrosis present
Macerated surrounding skin
Pressure/shear should be excluded
<table>
<thead>
<tr>
<th>When is life's end?</th>
<th>The 5 P’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>What's the difference between EOL and Palliative?</td>
<td>Prevention</td>
</tr>
<tr>
<td></td>
<td>Prescription</td>
</tr>
<tr>
<td></td>
<td>Preservation</td>
</tr>
<tr>
<td></td>
<td>Palliation</td>
</tr>
<tr>
<td></td>
<td>preference</td>
</tr>
</tbody>
</table>
EWMA consensus document

Physiologic changes that occur as a result of the dying process (days to weeks) may affect the skin and soft tissues and may manifest as observable (objective) changes in skin colour, turgor, or integrity.

These changes can be unavoidable and may occur with the application of appropriate interventions that meet or exceed the standard of care.

Diminished tissue perfusion, impaired skin oxygenation, decreased local skin temperature, mottled discoloration, and skin necrosis.

Suboptimal nutrition including loss of appetite, weight loss, cachexia and wasting, low serum albumin/pre-albumin, and low haemoglobin as well as dehydration.

Reduced mobility

(2009)
Non-blanchable erythema of intact skin.

Discolouration of the skin.

Warmth, oedema induration or hardness may also be used as indicators—particularly on individuals with darker skin.
CATEGORY ONE
Partial thickness skin loss involving the epidermis or dermis, or both.

The ulcer is superficial and presents clinically as an abrasion or blister.
CATEGORY TWO
SEROSSANGUINEOUS BLISTER
Full thickness skin loss involving damage to or necrosis of subcutaneous tissue.

May extend down to, but not through, underlying fascia.
CATEGORY THREE
Extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures.

May be with or without full thickness skin loss.
Avoidable Pressure Ulcer: “Avoidable” means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person’s clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.”

Unavoidable Pressure Ulcer: “Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person’s clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence”

(DH, 2009)
Reversing the Category:

Due to the level of original pressure damage, the category will always remain the same but might be classified as ‘healing’.
REPORTING PRESSURE DAMAGE

- All Pressure Ulcers of Category 2 and above
- Use the electronic safeguarding system /or your normal procedure.
- Free text - category, position, where from - service, how it occurred? avoidable
- All category 3 and 4 Ulcers deemed as avoidable will be escalated to SIRI.
- All category 3 and above should be reported to Tissue Viability. Is this True?
AREAS AT RISK
TIME TO CATEGORISE....
NO 5
No.7
No.9
ALAN HAS BEEN COMPLAINING OF A SORE HEEL THIS WHAT YOU FIND.
ALAN'S CARERS HAVE CALLED YOU TO SAY ALAN HAS A SMALL WOUND ON HIS BOTTOM WHAT SHOULD THEY DO?
EQUIPMENT
PRESCRIBING
WHO IS RESPONSIBLE?

- Prescriber
- Resource management
# PIN Request Form

## New PIN: [ ]

## Amend Existing PIN: [ ]

## Delete PIN: [ ]

### Prescriber Details

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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<td>Surname:</td>
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<td>Phone:</td>
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<tr>
<td>Title:</td>
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</tr>
<tr>
<td>Job Title:</td>
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### Cost Centres

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<th>Service Type</th>
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<tr>
<td>S&amp;CS</td>
<td>S</td>
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<tr>
<td>OLDT</td>
<td>L</td>
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<tr>
<td>Hospices</td>
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<tr>
<td>ORHT</td>
<td>R</td>
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<td>PMHT</td>
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<td>Tissue Viability</td>
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<td>Continuing Care</td>
<td>C</td>
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<tr>
<td>Children &amp; Families</td>
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### Team Codes

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<thead>
<tr>
<th>Team Name</th>
<th>Code</th>
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<tr>
<td>Management</td>
<td>1</td>
</tr>
<tr>
<td>NOC OCE</td>
<td>2</td>
</tr>
<tr>
<td>NOC Acute</td>
<td>3</td>
</tr>
<tr>
<td>OCTVS</td>
<td>4</td>
</tr>
<tr>
<td>City Adult Social Care Team</td>
<td>5</td>
</tr>
<tr>
<td>South Adult Social Care Team</td>
<td>6</td>
</tr>
<tr>
<td>Cherwell Adult Social Care Team</td>
<td>7</td>
</tr>
<tr>
<td>Vale Adult Social Care Team</td>
<td>8</td>
</tr>
<tr>
<td>West Adult Social Care Team.</td>
<td>9</td>
</tr>
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<td>AES (Central)</td>
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<td>AES (North)</td>
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<td>AES (South)</td>
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<td>AES (West)</td>
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<td>OLDT (City)</td>
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<td>OLDT (North)</td>
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<td>Mental Health</td>
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<td>VOA OT</td>
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<td>Community Hospitals</td>
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<tr>
<td>Case Management</td>
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<td>Churchill Hospital</td>
<td>22</td>
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<tr>
<td>John Radcliffe Hospital</td>
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<td>Horton Hospital</td>
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<tr>
<td>SCS HI Sensory</td>
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<td>SCS VI Sensory</td>
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<tr>
<td>SCS Dual Sensory</td>
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<td>Nursing (Central)</td>
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<td>Falls Service</td>
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<td>ECOL</td>
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<td>Children</td>
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<td>Care Home Support</td>
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<td>Hospital at Home</td>
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<td>PML</td>
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</table>
**Equipment request form**

<table>
<thead>
<tr>
<th>Date:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Swift / NHS Number:</td>
<td></td>
</tr>
<tr>
<td>Clients Name:</td>
<td></td>
</tr>
<tr>
<td>Male □</td>
<td>Female □</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number (including area code):</td>
<td></td>
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<tr>
<td>Mobile Number:</td>
<td></td>
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<tr>
<td>Address:</td>
<td></td>
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<tr>
<td>Postcode:</td>
<td></td>
</tr>
<tr>
<td>Diagnosis:</td>
<td></td>
</tr>
</tbody>
</table>

**Height:**

**Weight:** - Recent weight!

REFFERAL FOR THE PROVISION OF BEDS, SPECIAL CHAIRS, MATTRESSES AND CUSHIONS

- For assistance in assessing for the appropriate equipment please refer to the **Guidance on prescribing equipment**.
- Please print clearly as inability to read form will result in delay.
- All fields must be completed, any incomplete forms will be returned.
Weighing Service

Contract: OXFOR
Item Number: Weighing STD
Comments: This service includes the booking out of the driver, delivering to the home, undertaking a risk assessment, installing the equipment, providing any assistance requested by the prescriber, bagging the equipment for infection control purposes, placing in quarantine area, decontaminating ready for re-use.

Dimensions:

- Length: 0.00mm 0.00inch(s)
- Width: 0.00mm 0.00inch(s)
- Height: 0.00mm 0.00inch(s)
- Weight: 0.00Kg 0.00Lb

Safe Limits: weigh up to 300kg (47 stone)
Max Load: 0.00Kg 0.00Lb
Catalogue items
REQUEST ITEMS FOR PRESSURE AREA CARE.
Heel pressure ulcer damage

Repose boots

Heelift boots
Cushions and chairs
Cushions can cause problems
When sitting in a ‘neutral’ position with feet firmly on the floor, approximately 19% of body weight is supported by the feet and 75% of body weight is supported by the buttocks and sacrum. (Collins, 2001)
Too narrow
Riser recliner chair criteria

Clinical diagnosis of chronic oedema lymphoedema
Robust management plan
Referral to specialist services

Riser recliner chairs will not be supplied by tissue viability if...
• It's not part of a management plan.
• The patient is refusing to go to bed.
• The patient has mental capacity but is not concordant with care plans.
• Acute episode of illness.
• Palliative care for functional and comfort needs.
• Lymphoedema/ chronic oedema secondary to other medical conditions e.g. heart failure / cancers etc that is untreatable.
• Has active pressure damage to the sacrum
• For purely health needs

See portal for full criteria.
Wheelchair cushions
Paediatric Equipment
Bariatric Equipment
What about...?
Power cut and power mattresses
House fire and Pressure Relieving Equipment
ADERMA
Available in many shapes and sizes.
PLACES FOR ADERMA

- Trimmed strip behind the ear
- Trimmed strip under masks
- Sheet on the back of the head
- Sheet under the shoulder
- Sacrum over the shoulder
- Sheet under the knee
- Sheet between knees
- Heel over the knee or elbow
- Heel long way across the foot (mobile patients)
- Heel long way across the heel (immobile patients)
- Strip between fingers or toes
- Sheet for hand contractures
- Sacrum on the sacral area
- Strip down the spine
- Sheet around the foot
- Sacrum around the ankle
Is there anything you would change in this picture?
Any Questions?
NUTRITION
ALAN IS STRUGGLING WITH HIS MEALS
HOW WILL YOU MANAGE ALAN'S POOR DIET AND REDUCED APPETITE?
NUTRITION

- MUST score with associated care plan
- Well balanced diet
- Protein loading
- Calorie loading
- Adding value (patient leaflet)
- Continuous monitoring and evaluating of the management plan
ALAN IS FEELING UNWELL, HOT, AND LETHARGIC. HE HAS PAIN WHEN HE PASSES WATER. THIS IS HIS SAMPLE....
ANY QUESTIONS?