St Margaret's Hospice Care

PRESSURE ULCER PREVENTION

Tissue Viability Team 2020

St Margaret's Hospice Care

Somerset

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WE NEED YOU...

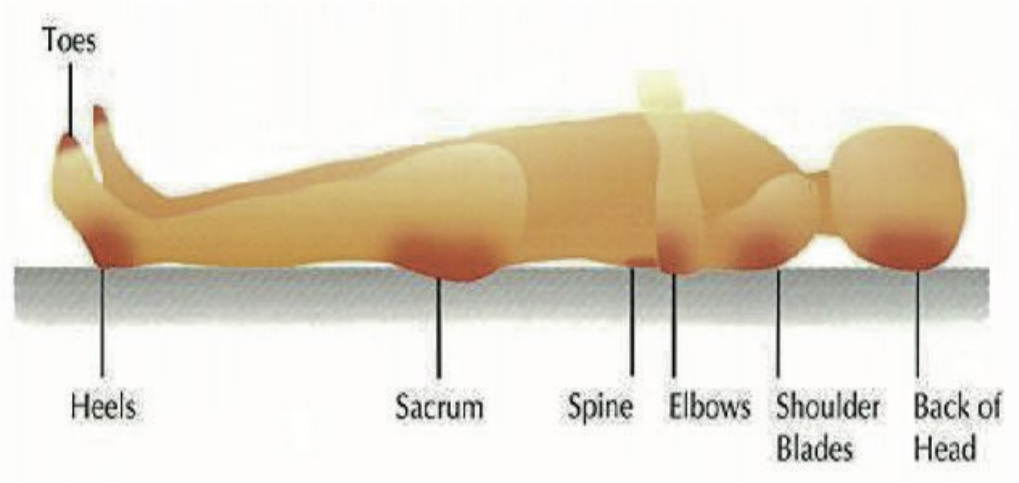
to be aSSKINg the right questions!

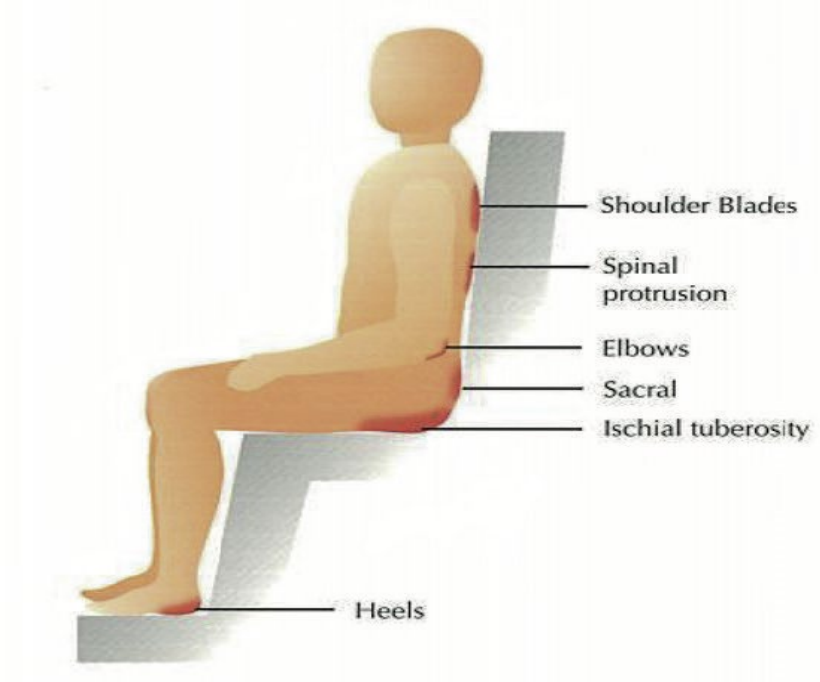
REMEMBER!

Don't call pressure injuries 'bed sores'. Call them pressure ulcers as they do not always happen in bed and are not always sore.

OSKA®

#stopthepressure





Buttocks
Elbows & ears
Sacrum
Trochanters
Spine/shoulders
Heels
Occipital
Toes

What to look for?

Non blanching erythema/redness.
Pain
Change in temperature over bony prominence
Boggy feeling
Hardened area
Discoloration
Broken skin

SKIN

- Full assessment. Erythema? Blanching/non-blanching.
- Appropriate pressure relieving equipment
- Use emollients instead of soap for cleansing
- Do not massage/rub area and dab to dry
- Protect skin with appropriate barrier product (see local policy)
- Non-blanching – remove pressure immediately. Inform team.
- If MASD present follow guidance
- Open wound? Conduct full assessment, compile care plans photograph and inform team.
- DTI? Offload 24/7 monitor, document, inform team.

SURFACE

- Mattress – Alternating pressure, lateral rotation
- Cushion – EHOB, Vicair, Valley, Integrated etc.
- Chair - Integrated, recliners.
- Pressure reducing or pressure relieving?
- Pressure **reducing** equipment (for lower risk patients) is designed to distribute the body weight over as large as possible skin surface area – e.g. specialist and memory foams or static air mattresses
- Pressure **relieving** equipment is designed to redistribute body weight periodically over different areas of skin – e.g. dynamic mattresses and cushions

KEEP MOVING

- Encourage mobility/independence whenever possible
- Repositioning regimes appropriate for each individual. Based on tissue tolerance, skin assessment, existing tissue damage, and patient ability/status.
- Refer to other healthcare professionals for advice/equipment

INCONTINENCE

- Full assessment and treat accordingly with appropriate products – pads, conveens, catheters.
- When incontinence pads are used ensure correct type/fit.
- Pads should be checked frequently as per individualised care plan
- When IASD is present treat accordingly with appropriate cream/paste/gel.

NUTRITION/HYDRATION

- Full assessment.
- Look for visible signs of weight loss e.g. loose clothes/jewellery/dentures
- Observe skin and oral mucosa for signs of dehydration
- Special dietary requirement?
- Are dietary supplements advisable?
- Little and often. Snacks at hand
- No bloating foods
- Drink and eat at separate times
- Exercise if possible
- Refer to other healthcare professional when appropriate
- Good hydration will help prevent constipation, PUs, urinary infections, falls, low blood pressure.

CONCORDANCE

- Provide full explanations of PUP strategies, including equipment
- Assess mental capacity for understanding decisions regarding PUP
- Patients without capacity, PUP must be delivered in their best interests
- Discuss/record reasons why patients/carers are declining PUP strategies

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SUMMARY

- **P**atient centered care planning
- **R**isk assessment – including concordance
- **E**quipment needs
- **S**kin & continence assessment
- **S**kin care
- **U**ndertake nutritional screening
- **R**epositioning
- **E**valuate effectiveness