PUTZ Falls Improvement Collaborative

Webinar : 12/11/2019

Update on Clinical/Technical elements

Helen Meagher & Pat Mc Cluskey

RANP Tissue Viability

Instructions

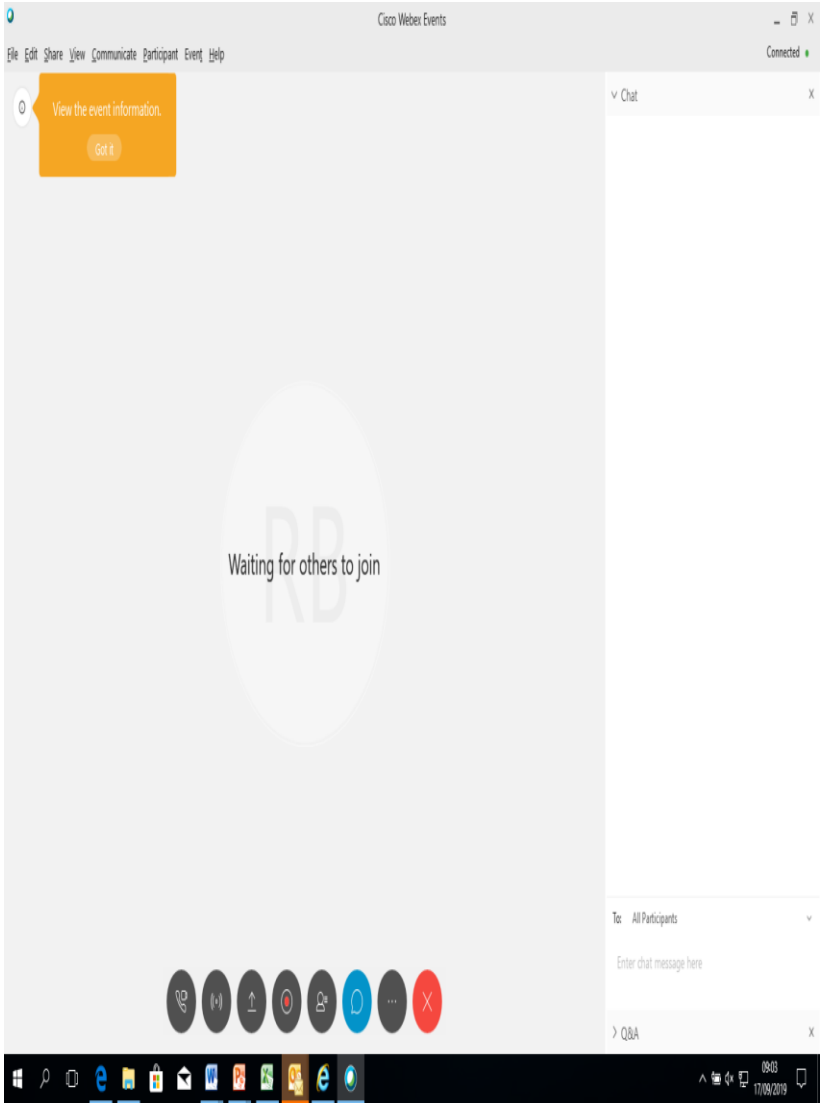
- Sound:

<u>Computer or dial in:</u>

Telephone no: 01-5260058

Event number: 847 415 534 #

- Chat box function
  - Comments/Ideas
  - Keep the questions coming



Pressure Ulcer to Zero Webinar

Outline

- Pressure ulcer risk assessment
- SSKIN Bundle
- Documentation
- Safety Cross

Pressure Ulcers to Zero

Pressure Ulceration

Definition:

"A pressure ulcer is a localised injury to the skin +/or underlying tissue usually over a bony prominence as a result of pressure or pressure in combination with shear" (International pressure ulcer classification 2014)

"A number of contributing or confounding factors are also associated with pressure ulcers; the significance has yet to be elucidated"(HSE 2018)

Pressure Ulcers to Zero

Identification of pressure ulcer risk factors

- Extremes of age (72% occur in >65yrs. Hospitalized >80's 7 times more likely than <45yrs)
- Malnutrition/Dehydration
- Incontinence/Moisture
- Immobility
- Factors affecting perfusion & oxygenation e.g. diabetes, cardiovascular instability/ nor epinephrine use, low BP, ABPI & oxygen use
- Previous history of pressure damage
- Medication
- Level of consciousness
- Sensory impairment
- Reduced sensation
- Acute illness
- Severe/chronic/ terminal illness (Scale 2009)
- Medical devices

However

- Any one of any age could get a pressure ulcer (Moore 2011)

- Holistic assessment is key
- Waterlow risk assessment carried out within **6 hours** of presentation.
- Used in combination with clinical judgement

Pressure Ulcers to Zero

Pressure Ulcer Risk Assessment, Prevention & Management

Identify patient at risk using:

- Holistic assessment
- Pressure ulcer risk assessment tool e.g. Waterlow/Braden etc
- Plus: Clinical judgement

Pressure Ulcer Prevention

Implement SSKIN Bundle

Pressure Ulcer Management & Prevent further pressure ulceration

Implement SSKIN Bundle

Plus Wound Management

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Prevention – SSKIN Bundle

- **S – Skin** – Assessment of the patient's skin
- **S – Surface** Provision of effective pressure redistributing surface (Timely)
- **K - Keep Moving** Appropriate repositioning
- **I – Incontinence** Managing moisture & incontinence
- **N - Nutrition** Adequate nutrition & hydration

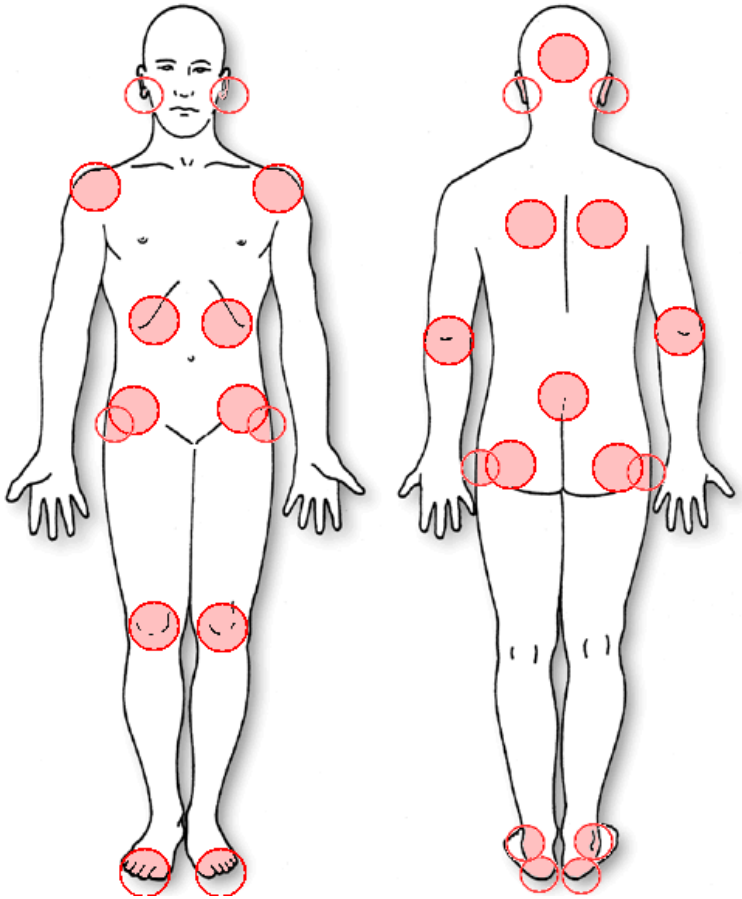
Pressure Ulcers to Zero

National Quality Improvement Programme

QPS DNE

S - Skin assessment

- Observe skin at every episode of care
- Blanching vs non blanching)/ Temperature/ Oedema/Consistency/ Localised Pain
- **React to Red!**
- Check for moisture/dryness
- Inspect under medical devices



Bony Prominences

S - Skin assessment

- As soon as possible but max of 6 hours
- As part of every risk assessment
- Ongoing based on setting, degree of risk and in response to any deterioration
- Record what you see in the patient's notes

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S - Surface

Support surface selection based on individual assessment & need.

Consider:

- Level of immobility & inactivity
- Microclimate control & shear reduction
- Size & weight of the individual
- Risk re development of new pressure ulcers
- Number, severity & location of existing pressure ulcer (HSE 2018)
- Consider lying & seating
- Patient location e.g. hospital/home

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S Surface

- Condition of mattress/cushion
- Is it working correctly
- Is incontinence wear necessary?

K – Keep Moving

- Assess patients ability to reposition
- Encourage to independently reposition as able
- Patient education
- Refer to OT/Physio if appropriate
- Repositioning plan if unable to self reposition

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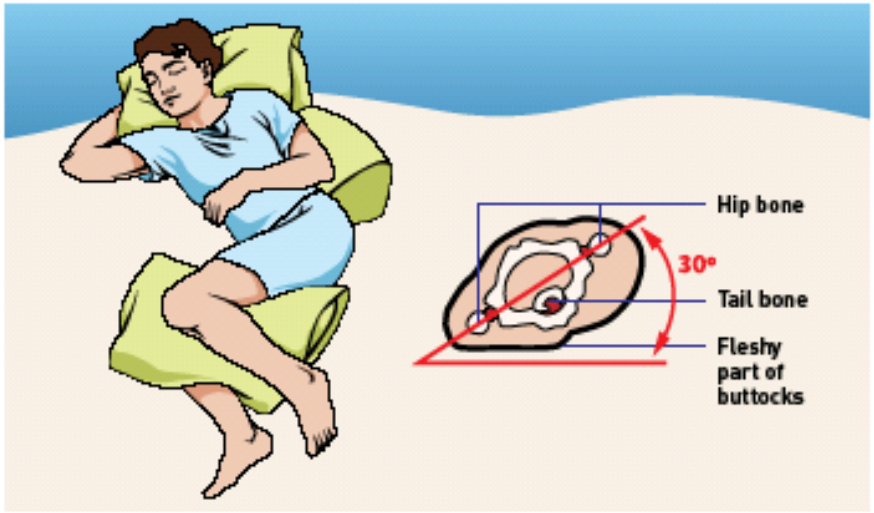
K-Keep Moving

- Reposition all patients at risk or with pressure ulcers unless contra-indicated (irrespective of support surface)
- Safe manual handling & use of repositioning aids
- Frequency of repositioning depends on :
  - Tissue tolerance
  - Level of activity & mobility
  - General medical condition
  - Overall treatment objectives
  - Skin condition
  - Comfort



30 degree tilt

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I - Incontinence

- Assess continence
- If wearing pads, do they fit correctly?
- Assess skin condition for signs of moisture damage
- Assess Skin care regime
- Two elements – Cleanse & Protect
- Cleanse skin after each episode of incontinence to remove urine/faeces/moisture
- Protect skin from moisture damage/ friction

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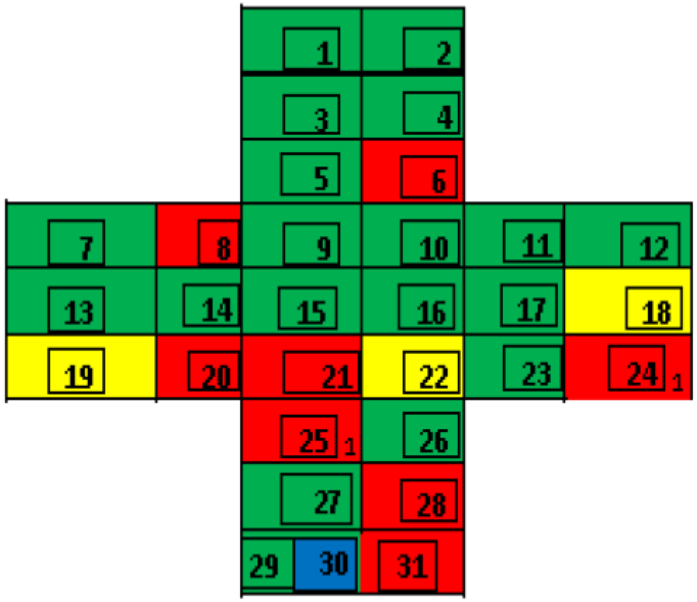
N- Nutrition

- Is nutritional intake sufficient? Consider if food/fluid chart required
- Has MUST score been recorded?
- Structured nutrition assessment & refer for dietetic assessment
- Encourage nutrition & hydration

Pressure Ulcers to Zero

Safety Cross



Colour	Code
	No new case
	New PU case identified
	Transferred with pressure ulcer within the same hospital (e.g. transfer from one ward to another).
	Admitted with PU from outside e.g. own home, care home other hospital

- One box per completed per day
- Record all newly observed pressure ulcers once only on the safety cross
- Record additional details in the legend box on the chart if required
- Use safety cross as a visual tool
- Report pressure ulcers as per HSE (2018) guide and local policy

Pressure Ulcers to Zero

SSKIN BUNDLE

Pressure Ulcer Prevention Care Plan

Commence when Waterlow Score ≥ 10

Addressograph

Frequency of care delivery (circle as appropriate) 1hrly 2hrly 3hrly 4hrly													
Date													
Time (24 Hour Clock)													
SURFACE	See advice re surfaces on LMHG Guideline on Pressure Ulcer Prevention (on T Drive). Indicate each day if Foam ☐ or Pressure Relieving Mattress ☐ (tick)												
Mattress appropriate & functioning correctly:													
Appropriate seating													
Heel protectors													
SKIN INSPECTION	Inspect skin at bonny prominence every 2 – 4 hours. Existing Pressure Ulceration: Y/N (Circle). Stage* & site of existing ulceration recorded in wound assessment chart: Y / N (Circle)												
Pressure areas checked													
New Redness State Site:													
KEEP MOVING	Frequency of repositioning is determined by skin inspection. If red at least 2 hourly.												
B R Side													
E L Side													
D Back													
CHAIR													
Standing / Mobilising													
INCONTINENCE	Incontinence Related Skin Care regimen Implemented (on T Drive, Tissue Viability Folder) Y / N												
Dry and clean													
Peri-anal skin healthy													
NUTRITION	Fluid Balance Chart / Food Chart in progress Y/N (circle and continue). Otherwise record below:												
Meal / snack taken													
Drink taken													
Supplements taken													
Signature													
Grade: S/N = Staff Nurse,													
HCA = Health Care Assistant													
OT = Occupational Therapist													
D = Dietician													
P = Physiotherapist													
S = Student,													
SALT													

KEY: Care Delivered : √ = YES X = NO (If NO Document & Explain in Nursing notes)

RED SKIN – RELIEVE PRESSURE – REVERSE DAMAGE

Patient Pressure Ulcer Prevention Information booklet given ☐

Category/ Stage: Please refer to the International NPUAP/ EPUAP Pressure Ulcer Classification system

Pressure Ulcers to Zero

Pressure Ulcers to Zero

SSKIN BUNDLE

Pressure Ulcer Prevention Care Plan
(commence when Waterlow Score > 10

Frequency of care delivery (circle as appropriate) 1hrly 2hrly 3hrly 4hrly													
Date													
Time (24 Hour Clock)													
SURFACE	See advice re surfaces on LMHG Guideline on Pressure Ulcer Prevention (on T Drive). Indicate each day if Foam ☐ or Pressure Relieving Mattress ☐ (tick)												
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Drink taken													
Supplements taken													

Where to look for pressure ulcers:

- 'bony prominences', for example on your elbows or shoulders
- swollen skin over bony points
- areas where skin may be damaged due to temperature changes

If you or your carer notice possible or actual signs of damage, you should tell your health care staff immediately. Contact the nursing staff if you are in hospital, or your public health nurse or GP, if you are at home.

Get advice

Your nurse or healthcare professional (and your carer if you have one) should tell you about how to reduce pressure on areas of your body that are at risk of pressure damage. This advice should include tips on:

- the correct seating and lying positions
- how to adjust your lying or sitting position
- how often you need to move or be moved and
- which equipment you should use

Your nurse or healthcare professional should also advise you how to avoid pressure by, for example, making sure your bedding is free of creases. In addition, your clothing should not have:

- thick seams
- zips
- studs or
- buttons

Your shoes and socks should not be too tight.

Would you like to know more?

Ask your nurse or healthcare professional or visit www.hse.ie

Information Source

NICE Patient Information Pressure Ulcers

Building a Better Health Service | Seirbhís Sláinte Nios Fearr á Forbairt
National Quality Improvement Team

Plain English
Approved by NALA

Pressure Ulcers to Zero

How to recognise and relieve pressure ulcers

A patient information leaflet

Building a Better Health Service | Seirbhís Sláinte Nios Fearr á Forbairt
National Quality Improvement Team

What are pressure ulcers?

Pressure ulcers are also known as bedsores, pressure sores and decubitus ulcers. They are localised injuries to the skin, or the tissue underneath the skin, or both. Sitting in a chair or lying in bed puts a lot of pressure on the skin over what are called 'bony prominences'. These are areas where bones or joints may 'stick out' because there is very little flesh over them, for example your knees or elbows.

How does 'pressure' cause harm?

Body weight squashes the tissues in those who are unable to move to relieve pressure. This reduces the blood supply to the affected areas, squashes cells and reduces the oxygen and nutrient supply to the tissues. This pressure combined with 'shear' can cause pressure ulcers.

What is 'shear'?

'Shear forces' or 'shear strain' occurs in soft tissue when these tissues are stretched, for example, when a person is sliding down in a chair or in bed, or when sitting down and the tissue stretches around the bones.
Shearing is a mixture of pressure and friction. It is caused when two surfaces have opposing forces, for example, when someone slides over a surface, like a bed or chair.

Where are pressure ulcers found?

Pressure ulcers usually occur over bony areas, in particular:

- shoulders
- elbows
- buttocks and
- heels

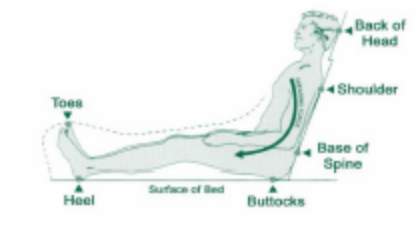
Pressure ulcers can develop in the deeper layers of the tissue and may not always result in a break in the skin.

Who gets pressure ulcers?

Anyone who is confined to bed or a chair and is unable to move is at risk. A number of other factors increase the risk in immobile people, for example:

- loss of sensation
- loss of bowel or bladder control or
- poor nutrition

You are also at risk of getting a pressure ulcer when you are unwell and you are unable to move to change your position regularly.



This picture identifies the areas on the body where pressure ulcers are most likely to develop.

What can you do to relieve pressure ulcers?

The best things you can do to relieve the pressure whether you are lying in bed or sitting in a chair are to:

- keep active and
- change your position frequently

If you are unable to move yourself, the staff in the unit, or your carers if you are at home, will help to change your position regularly. Special equipment such as air mattresses, cushions and booties may be used to reduce the pressure in particular places.

Look after your skin

- Keep your bedding dry.
- Let staff or your carer know if your clothes or bedding are damp or creased.
- Tell staff or your carer if you have any tenderness or soreness over a bony area.
- Tell staff or your carer if you notice any reddened, blistered or broken skin.
- Avoid rubbing or massaging your skin over bony parts of the body.
- Use a mild soap.
- Moisturise dry skin.

Eat a balanced diet

Eating a healthy nutritious diet and drinking fluids will help keep your skin healthy.

Check your skin

If you are willing and able to do so, staff can teach you how to check your skin. Training can also be given to your carer (if you have one). You or your carer should inspect your skin regularly, looking for signs of possible or actual damage.

The signs to look for are:

- purplish or bluish patches on dark-skinned people
- red patches on light-skinned people
- swelling
- blisters
- shiny areas
- dry patches

Differentiating between pressure ulcers and moisture lesions

Parameter	IAD	Pressure ulcer
History	Urinary and/or faecal incontinence	Exposure to pressure/shear
Symptoms	Pain, burning, itching, tingling	Pain
Location	Affects perineum, perigenital area; buttocks; gluteal fold; medial and posterior aspects of upper thighs; lower back; may extend over bony prominence	Usually over a bony prominence or associated with location of a medical device
Shape/edges	Affected area is diffuse with poorly-defined edges/may be blotchy	Distinct edges or margins
Presentation/depth	Intact skin with erythema (blanchable or non-blanchable), with/without superficial, partial-thickness skin loss	Presentation varies from intact skin with non-blanchable erythema to full-thickness skin loss Base of wound may contain non-viable tissue
Other	Secondary superficial skin infection (e.g. candidiasis) may be present	Secondary soft tissue infection may be present

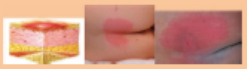
Citation: Beeckman D et al. Proceedings of the Global IAD Expert Panel. Incontinence associated dermatitis: moving prevention forward. Wounds International 2015. Available to download from www.woundsinternational.com

Differentiating between pressure ulcers and moisture lesions

Appendix 2. HSE 2018 Pressure Ulcer Category/Staging System Recommendation

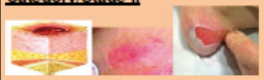
Definition: *"A pressure ulcer is a localised injury to the skin and / or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance has yet to be elucidated"*

Category / Stage I



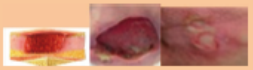
Category/ Stage I: Intact skin with non – blanchable redness of a localised area usually over a bony prominence. Discolouration of the skin, warmth, odema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching. The area may be painful, firm, soft, warmer or cooler as compared to adjacent skin. (EPUAP 2009)

Category/Stage II



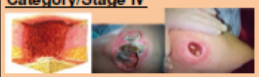
Category / Stage II: Partial thickness skin loss of dermis presenting as a shallow ulcer with a red pink wound bed, without slough. May present as an intact or open/ ruptured serum filled blister filled with serous or sero- sanginous fluid. Presents as a shiny or dry shallow ulcer without slough or bruising. (EPUAP 2009).

Category/Stage III

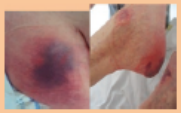


Category / Stage III: Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. The stage may include undermining or tunnelling (EPUAP 2009).

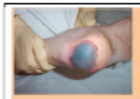
Category/Stage IV



Category / Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. This stage often includes undermining and tunnelling. Exposed bone / muscle is visible or directly palpable (EPUAP 2009).



In individuals with non-blanchable redness and purple/maroon discoloration of intact skin combined with a history of prolonged, unrelieved pressure/shear, this skin change may be an indication of emerging, more severe pressure ulceration i.e. an emerging **Category/Stage III or IV Pressure Ulcer.** Clear recording of the exact nature of the visible skin changes, including recording of the risk that these changes may be an indication of emerging more severe pressure ulceration, should be documented in the patients' health record. These observations should be recorded in tandem with information pertaining to the patient history of prolonged, unrelieved pressure/shear.
It is estimated that it could take **3-10 days** from the initial insult causing the damage, to become a **Category/Stage III or IV Pressure Ulcer** (Black et al, 2015).



Stable eschar (dry adherent, intact without erythema or fluctuance) on the heel serves as the body's biological cover and should not be removed. It should be documented as at least Category / Stage III until proven otherwise.

Scottish Excoriation & Moisture Related Skin Damage Tool

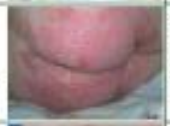
Skin damage due to problems with moisture can present in a number of different ways. This tool aims to help you identify the cause to aid in decision making for treatments.
Moisture may be present on the skin due to incontinence (urinary and faecal), perspiration, wound exudate or other body fluids e.g. lochia, amniotic fluid.
Lesions caused by moisture alone should not be classified as pressure ulcers.

Combination Lesions:
These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage but awareness of other causes and treatments is needed.
See Pressure Ulcer Grading Tool

Incontinence Related Dermatitis (IRD)

Mild
Erythema (redness) of skin only. No broken areas present.

Moderate
Erythema (redness), with less than 50% broken skin.
Oozing and/or bleeding may be present.



Severe
Erythema (redness), with more than 50% broken skin.
Oozing and/or bleeding may be present.

Treatment:
Prevention/Mild IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply Moisturiser +/or skin protectant e.g. barrier cream/film which does not affect absorbency of continence products.

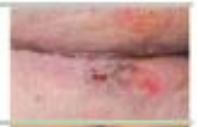
Moderate-Severe IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply liquid/spray skin protectant, OR barrier preparation, if no improvement refer to local guidelines or seek specialist advice.

NB:
Observe for signs of skin infection, e.g. candidiasis, and treat accordingly (do not use barrier films as this will reduce effectiveness of treatment)

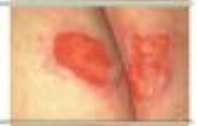
www.tissueviabilityscotland.org

Moisture Lesions:
Skin damage due to exposure to urine, faeces or other body fluids

Location
Located in peri-anal, gluteal, cleft, groin or buttock area.
Not usually over a bony prominence.



Shape
Diffuse often multiple lesions.
May be 'copy', 'mirror' or 'kissing' lesion on adjacent buttock or anal-cleft.
Linear



Edges
Diffuse irregular edges.

Necrosis
No necrosis or slough.
May develop slough if infection present.

Depth
Superficial partial thickness skin loss.
Can enlarge or deepen if infection present.

Colour
Colour of redness may not be uniform. May have pink or white surrounding skin (maceration).
Peri-anal redness may be present.

Differentiating between pressure ulcers and moisture lesions

	Pressure ulcer	Moisture lesion
Cause	Pressure/shear	Moisture
Location	Over bony prominences	May be over bony prominences, skin folds, anal cleft, perianal area
Shape	Circular or regular shape	Diffuse superficial spots or irregular shape. Linear shape in cleft and skin folds
Depth	Partial to full thickness, from grade 2-4	Superficial – partial thickness
Necrosis	Present in full-thickness pressure damage	No necrosis or eschar present
Edges	Distinct edges, clear demarcation	Diffuse irregular edges
Colour	Red, yellow, green, black	Redness that is not uniformly distributed. Pink or white maceration

Questions?

Recap: on what to bring on day 2

- Story board Template

- Try completing:

Tool 1: Project on a page
Tool 2: Stakeholder map
Tool 3: Aim statement/Driver diagram
Tool 4: Project Charter
Tool 10: Measurement Plan
Tool 12: PDSA template
Tool 6: Effective meetings

www.qualityimprovement.ie

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Missed a webinar – Don't worry you can watch recorded webinars on HSE QID PUTZ Falls webpages

See you soon in Cavan or Cork

Any questions/ queries:

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