React to Red
Pressure Ulcer Prevention Training
Aim of React to Red

To understand:

• The concept of React to Red (Responsibility & Guidance Document)
• What a pressure ulcer is and how it develops
• Risks and causes
• The categories of pressure ulcers
• Prevention and management strategies
• Correct use of equipment
• Documentation and responsibility
Why Bother.... ?

• The elderly in care homes are a particularly vulnerable group, often suffering with age associated illnesses, co-morbidities and poor mobility

• All of this vastly increases the risk of developing a pressure ulcer

• The total cost in the UK is estimated to be £1.6 billion to £2.6 billion annually (2007)
Tried and Tested

• Developed & implemented by Bassetlaw CCG

• 28 care homes in total

• 47% of staff had never received any previous pressure ulcer prevention training

• Staff unable to recognise a pressure ulcer until severe

• 55% Reduction in Pressure Ulcers in 12 months
What is a Pressure Ulcer?

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

NPUAP/EPUAP (2014)
Categories of pressure ulcers

Category 1

• A lasting patch of red skin that does not turn white when you press it with your finger.

(Non-blanching erythema)
Category 2

• Intact skin blisters filled with CLEAR fluid (separation of dermis/epidermis)
• Superficial skin loss/open sore or abrasion which may weep – WITHOUT SLOUGH
• There may be a red/pink area surrounding the area
Category 3

• The ulcer becomes a cavity that goes below the skin surface.

• SLOUGH WILL NORMALLY BE PRESENT

• This is a Serious Incident
Category 4

- The ulcer deepens & reaches into the muscle
- This can lead to bone & tendon being exposed
- Slough and/or necrosis present
- This is a serious Incident
Un-gradeable

- Full thickness skin loss, depth unknown.
- The actual depth is obscured by slough and/or necrosis.
- This is a Serious Incident
Suspected Deep Tissue Damage

• Purple area of **INTACT SKIN** or blood filled **INTACT** blister due to damage of underlying soft tissue.

• This is a Serious Incident
IMPACT

• Quality of life/life threatening

• Increased workload & demands

• Financial Burden

• Reputation of the home at risk

• CQC/Safeguarding involvement
Risk Factors

• Pressure, Shearing & Friction
• Decreased mobility – (Falls training)
• Sensory Impairment – (Falls training)
• Incontinence & Moisture – (Infection Prevention training)
• Acute, chronic and terminal illness (NEWS and deteriorating resident training)
• Posture
• Previous or current pressure ulcer
• Age
• Poor Nutrition and hydration (Nutrition & Hydration training)
• Memory problems and concordance
## Skin Bundle

<table>
<thead>
<tr>
<th>Surface &amp; Safety</th>
<th>Reposition patient every</th>
<th>Level of Mobility</th>
<th>Equipment in Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin – inspection</td>
<td>hours in bed</td>
<td>Full</td>
<td>Restricted</td>
</tr>
<tr>
<td></td>
<td>hours in chair</td>
<td></td>
<td>Chaired bound</td>
</tr>
<tr>
<td>Keep moving</td>
<td></td>
<td></td>
<td>Bedbound</td>
</tr>
<tr>
<td>Incontinence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Date:

<table>
<thead>
<tr>
<th>Time (circle hours to be completed)</th>
<th>12am</th>
<th>1am</th>
<th>2am</th>
<th>3am</th>
<th>4am</th>
<th>5am</th>
<th>6am</th>
<th>7am</th>
<th>8am</th>
<th>9am</th>
<th>10am</th>
<th>11am</th>
<th>12pm</th>
<th>1pm</th>
<th>2pm</th>
</tr>
</thead>
</table>

### Surface & Safety

- Mattress and cushion are working correctly and are still appropriate for the patient's needs. The patient is safe and comfortable.
- Pain (Tick if analgesia administered)
- Appropriate footwear
- Walking aids available

### Keep moving

- Keeping Moving
  - Position changed - in bed
  - Position changed - sat out

### Incontinence

- Skin Condition:
  - Heels: (remove stockings / socks)
  - Heels - offload
  - Sacrum
  - Buttocks
  - Hip
  - Elbow
  - Bony prominences
  - Barrier cream / spray applied

### Nutrition

- Offer fluids, including prescribed protein drinks; maintain daily fluid balance chart. Dietician
- Drinks available
- Fluid balance chart completed
- Assisted with feeding
S - SURFACE

• If your resident is not very mobile and unable to change their own position, they need the surface they are using to be reviewed regularly (mattress/cushion)

• If you are concerned about the surface your resident is on, you can discuss this further with your DN Team Link
S - SKIN INSPECTION

What to look and feel for:

• Redness/erythema (non blanching test )
• Pain and soreness
• Temperature (high or very low can indicate sepsis) – NEWS training
• Boggy area of tissue
• Hardened area of tissue
• Discolouration (dark red/purple/black)
• Broken skin/Ulcer
Pressure areas to check

Pressure points
Best shot
B
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H
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T

As you may have observed, most pressure sores occur over a bony prominence.
K - KEEP MOVING

• It is important to AVOID putting pressure on vulnerable areas or where pressure ulcers have formed

• Moving and regularly changing position relieves the pressure allowing the blood supply to return

• If your resident is identified as at RISK, you should commence a repositioning schedule which must state how often and in what way your resident needs repositioning (page 19)
30° Tilt
Relieving Pressure

Use available resource i.e. Repose or the Devon Boot
Moisture damage can occur to the skin by prolonged contact with moisture to the skin 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

(page 21-22)
Moisture Lesions
N - Nutrition and Pressure Ulcers

Malnutrition
- Reduced immunity
- Poor mobility
- Poor wounding healing
- Falls
- Infections
- Frequent admissions
- Longer hospital stays
- Poor health
- Death

Malnutrition = weight loss and/or low body weight.

Pressure Ulcers
- Need extra **Protein** to help healing
- Need extra **Calories** – otherwise protein stores get used to power the body instead of for healing

Dehydration

if nutritional needs not met
Spotting malnutrition

- Weight loss
- Loose fitting clothes / jewellery
- Loose fitting dentures
- Wasted muscles – arms, legs, hands, face
- Poor wound healing
- Pressure ulcers
- Poor appetite
- Impaired swallow
- Altered taste
Documentation

• Ensure Skin Inspections are performed on admission/discharge & as a **MINIMUM** of **ONCE PER SHIFT** & document outcome

• Document any omissions with rationale

• All referrals to the DN Team/TVN/PU Team

• Ensure all relevant care plans are up to date & reviewed
https://www.youtube.com/watch?v=Syc-hByVGF0...
REMEMBER....
PREVENTION IS BETTER THAN
THE CURE!!
ANY QUESTIONS