ENHANCED HEALTH IN CARE HOMES

WORKING TOGETHER TO IMPROVE QUALITY

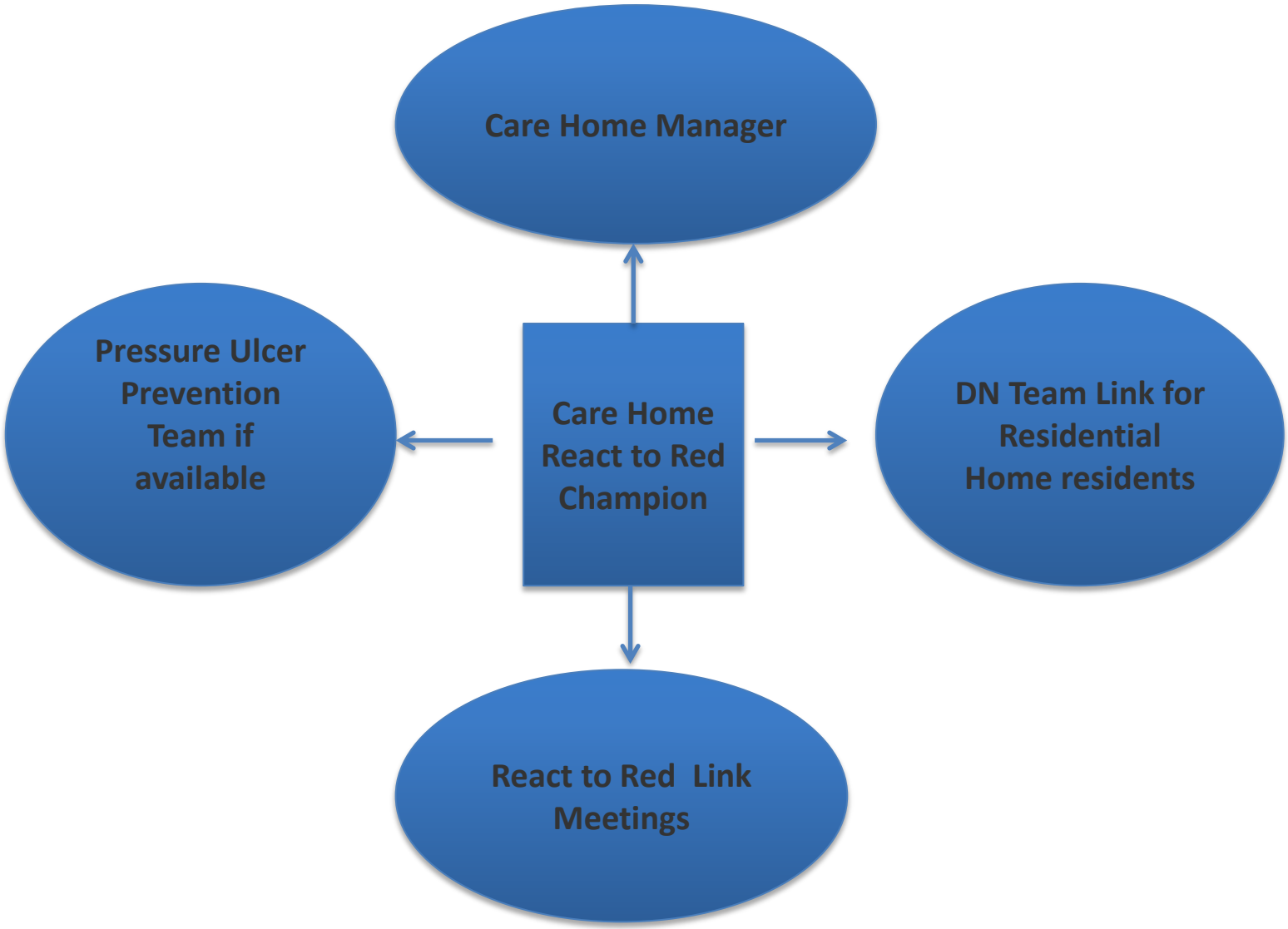
React to Red
Pressure Ulcer Prevention Training

REACT TO RED

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


Care Home Manager
Pressure Ulcer Prevention Team if available
Care Home React to Red Champion
DN Team Link for Residential Home residents
React to Red Link Meetings

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

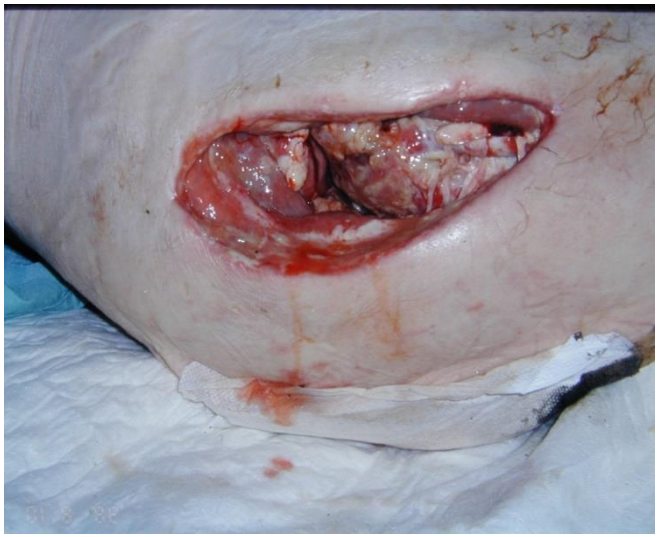
- Developed & implemented by Bassetlaw CCG
- 28 care homes in total
- 47% of staff had never received any previous pressure ulcer prevention training
- Staff unable to recognise a pressure ulcer until severe
- 55% Reduction in Pressure Ulcers in 12 months

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)

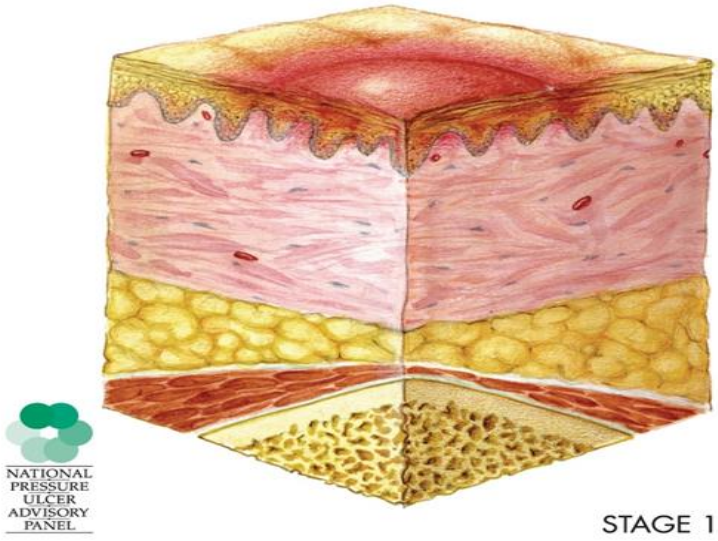


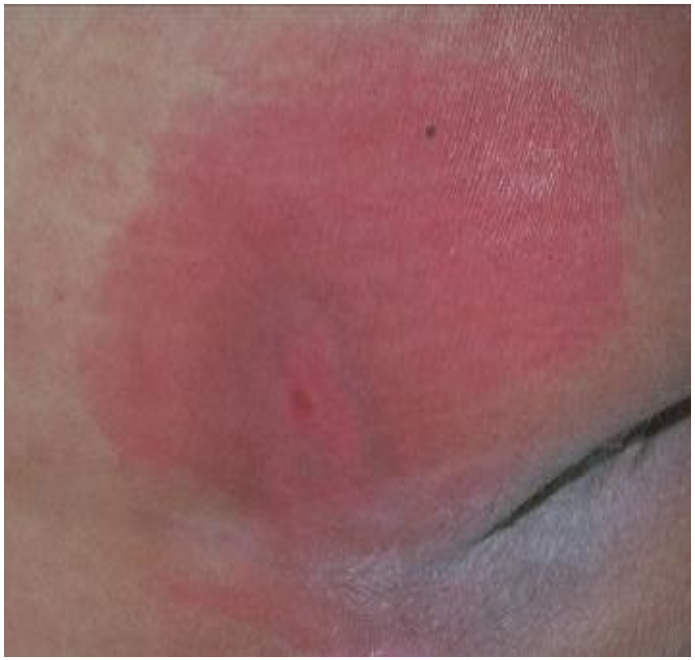
Categories of pressure ulcers

Category 1

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

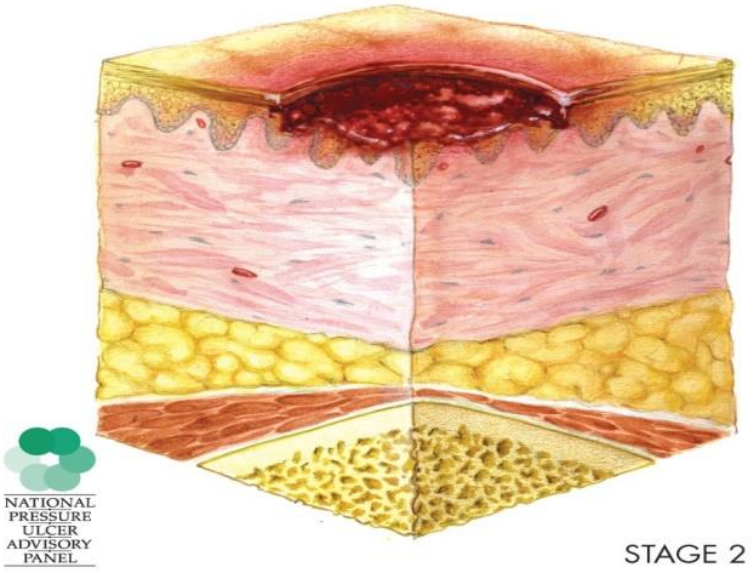
(Non-blanching erythema)

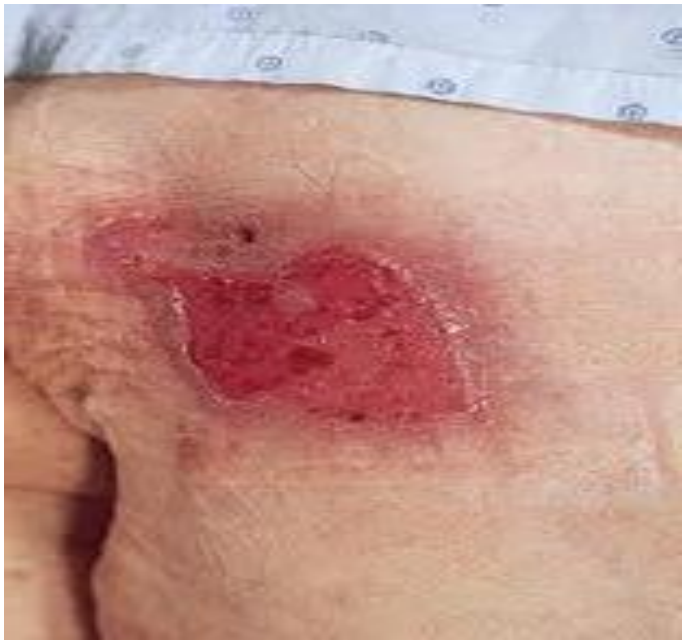




Category 2

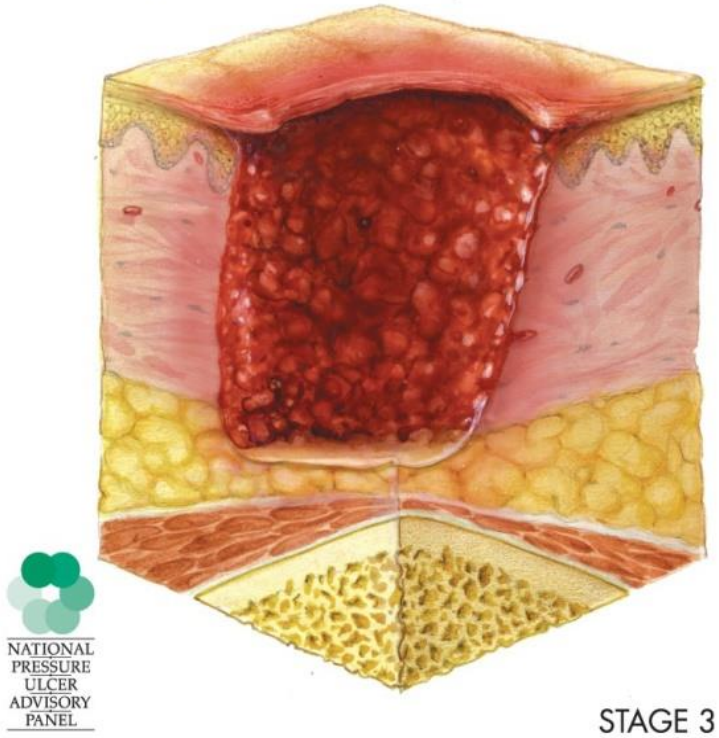
- Intact skin blisters filled with CLEAR fluid (separation of dermis/epidermis)
- Superficial skin loss/open sore or abrasion which may weep – WITHOUT SLOUGH
- There may be a red/pink area surrounding the area

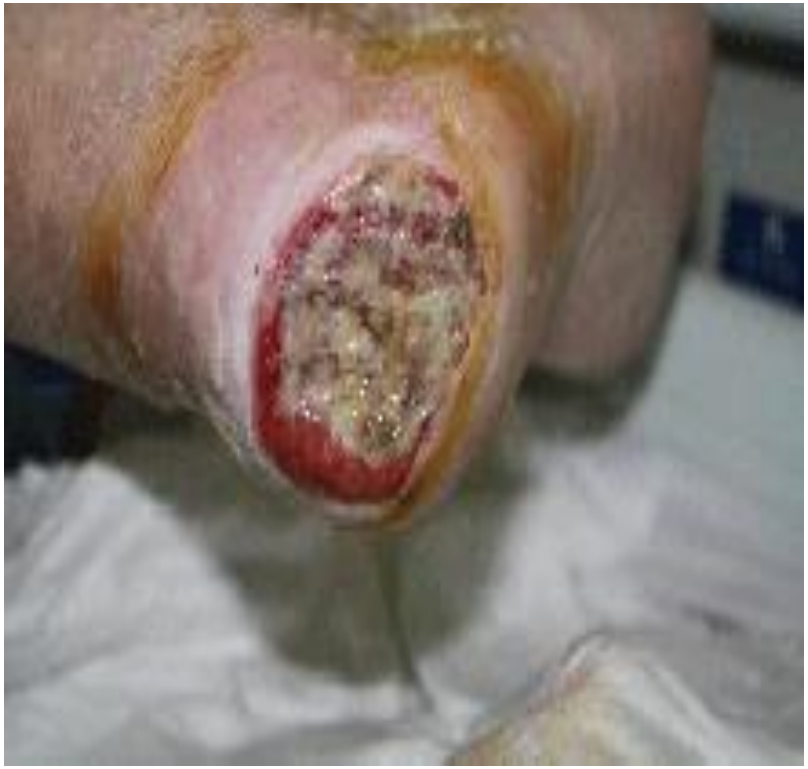




Category 3

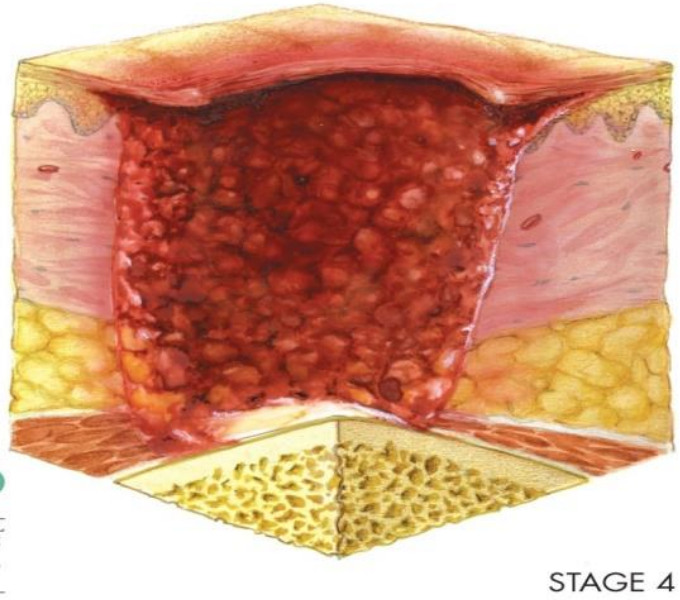
- The ulcer becomes a cavity that goes below the skin surface.
- SLOUGH WILL NORMALLY BE PRESENT
- This is a Serious Incident

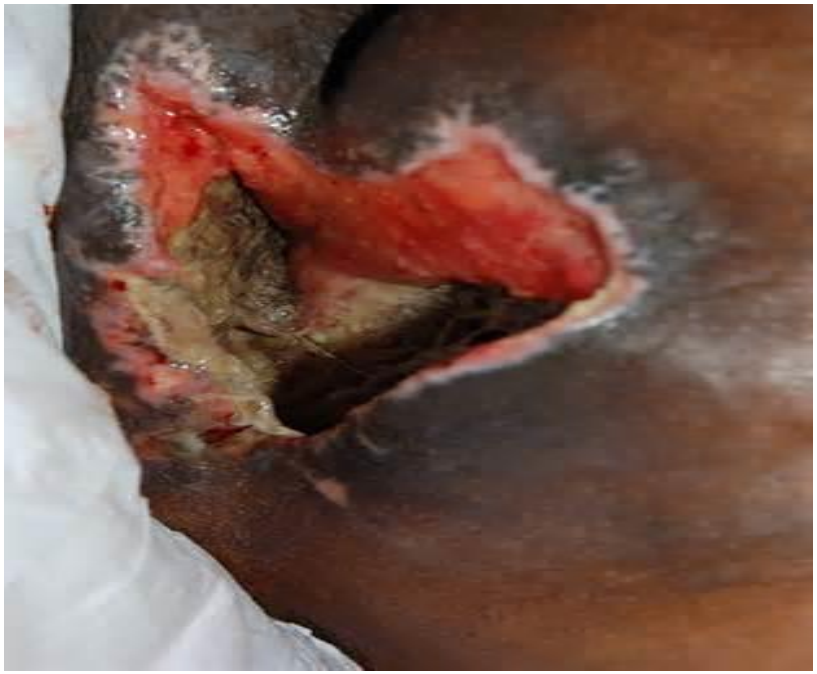




Category 4

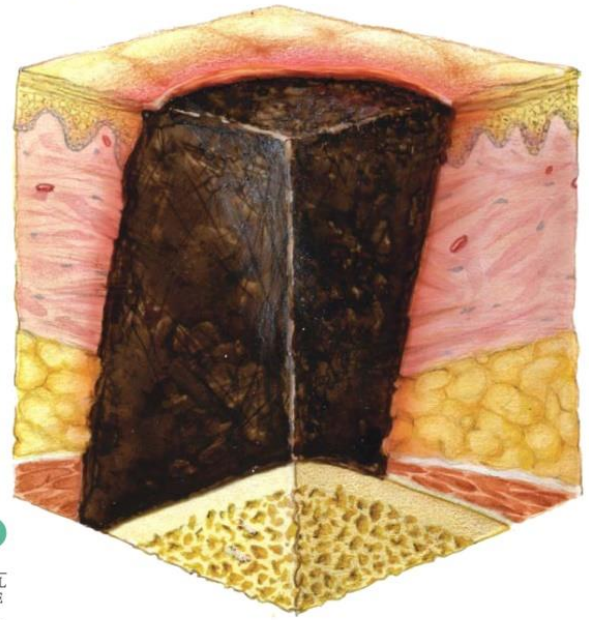
- The ulcer deepens & reaches into the muscle
- This can lead to bone & tendon being exposed
- Slough and/or necrosis present
- This is a serious Incident





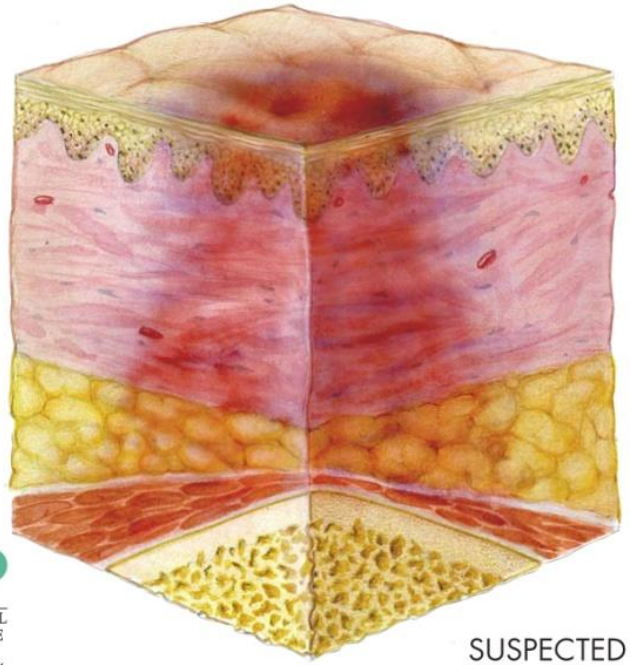
Un-gradeable

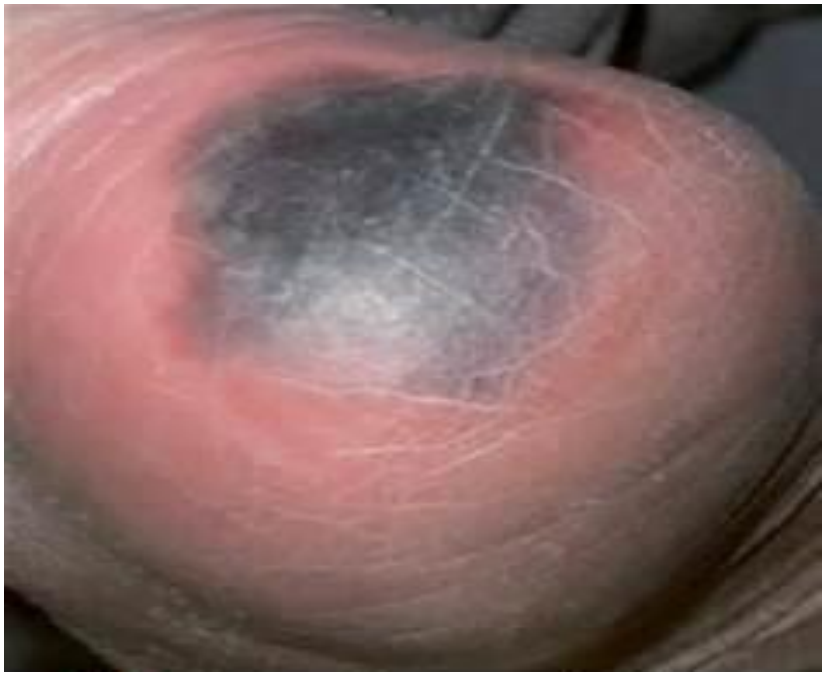
- Full thickness skin loss, depth unknown.
- The actual depth is obscured by slough and/or necrosis.
- This is a Serious Incident



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

Surface

Skin – inspection

Keep moving

Incontinence

Nutrition

Patient Name															
Reposition patient every **hours in bed**					**Level of Mobility**		**Prescribed barrier cream / spray**								
Reposition patient every **hours in chair**					**Full**										
Equipment in Use:					**Restricted**										
					Chairbound										
					Bedbound										
Date:	ENTER N/A IF SECTION NOT APPLICABLE														
Maelor score:	**Risk of falls:** YES / NO				**Dementia Diagnosis:** YES / NO										
Time (circle hours to be completed)	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm
Surface & Safety	Mattress and cushion are working correctly and are still appropriate for the patients needs. The patient is safe and comforta														
Mattress															
Cushion															
Orientation	**FA** = Fully alert **D** = Drowsy **A** = Asleep **MC** = Mild confusion/disorientation **SC** = Severe confusion/disorientation														
Pain (Tick if analgesia administered)															
Appropriate footwear															
Walking aids available															
Keeping Moving	**L** = left side 30 degree tilt **R** = right side 30 degree tilt , **B** = back, **S** = stood to relieve pressure														
Position changed - in bed															
Position changed - sat out															
Skin Condition:	**N** = normal **R** = red **P**= purple discolouration **D** = dressing in place **C** = Contacted D/N tean														
Heels (remove stockings / socks)															
Heels - offload															
Sacrum															
Buttocks															
Hip															
Elbow															
Bony prominences															
Barrier cream / spray applied															
Incontinence															
Continent															
Catheter patent															
Urinary incontinence															
Bowels opened															
Bowel incontinence															
Toilet offered															
Clean and dry															
Barrier cream / spray applied															
Nutrition	**Offer fluids, including prescribed protein drinks, maintain daily fluid balance chart. Dietcian**														
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)

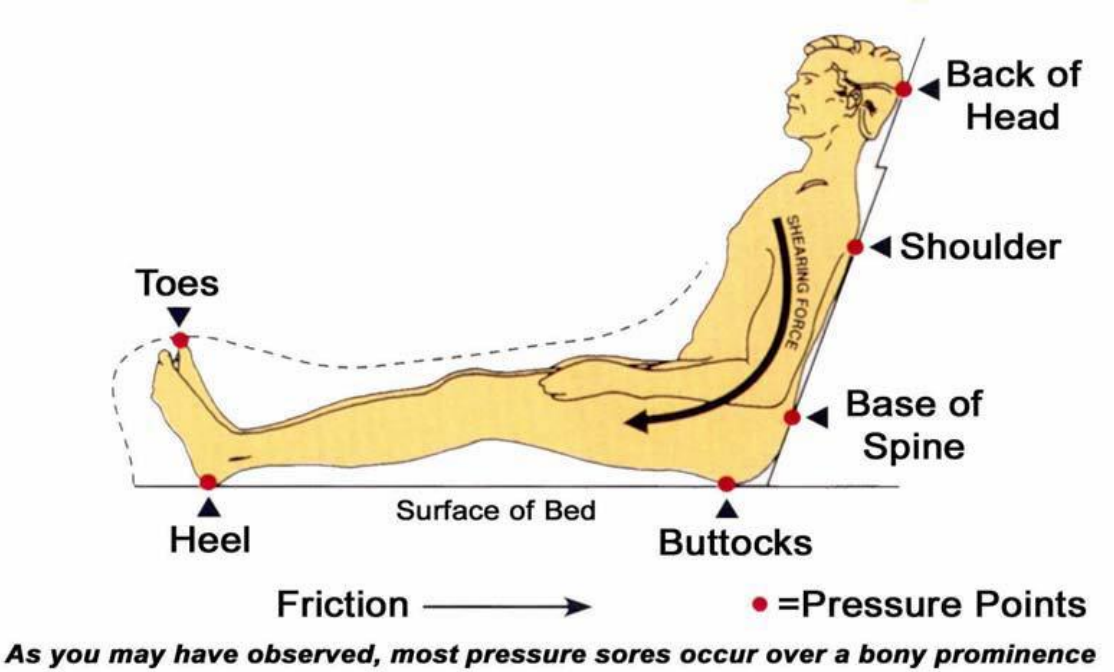
- If you are concerned about the surface your resident is on, you can discuss this further with your DN Team Link

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



As you may have observed, most pressure sores occur over a bony prominence

Pressure points
Best shot
B
E
S
T
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H
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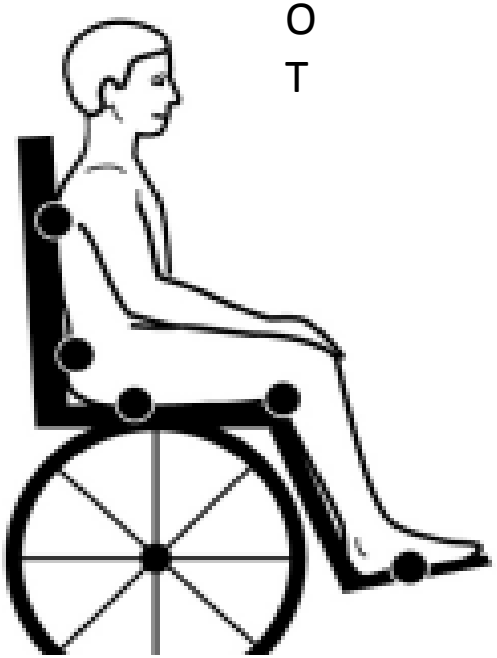
T



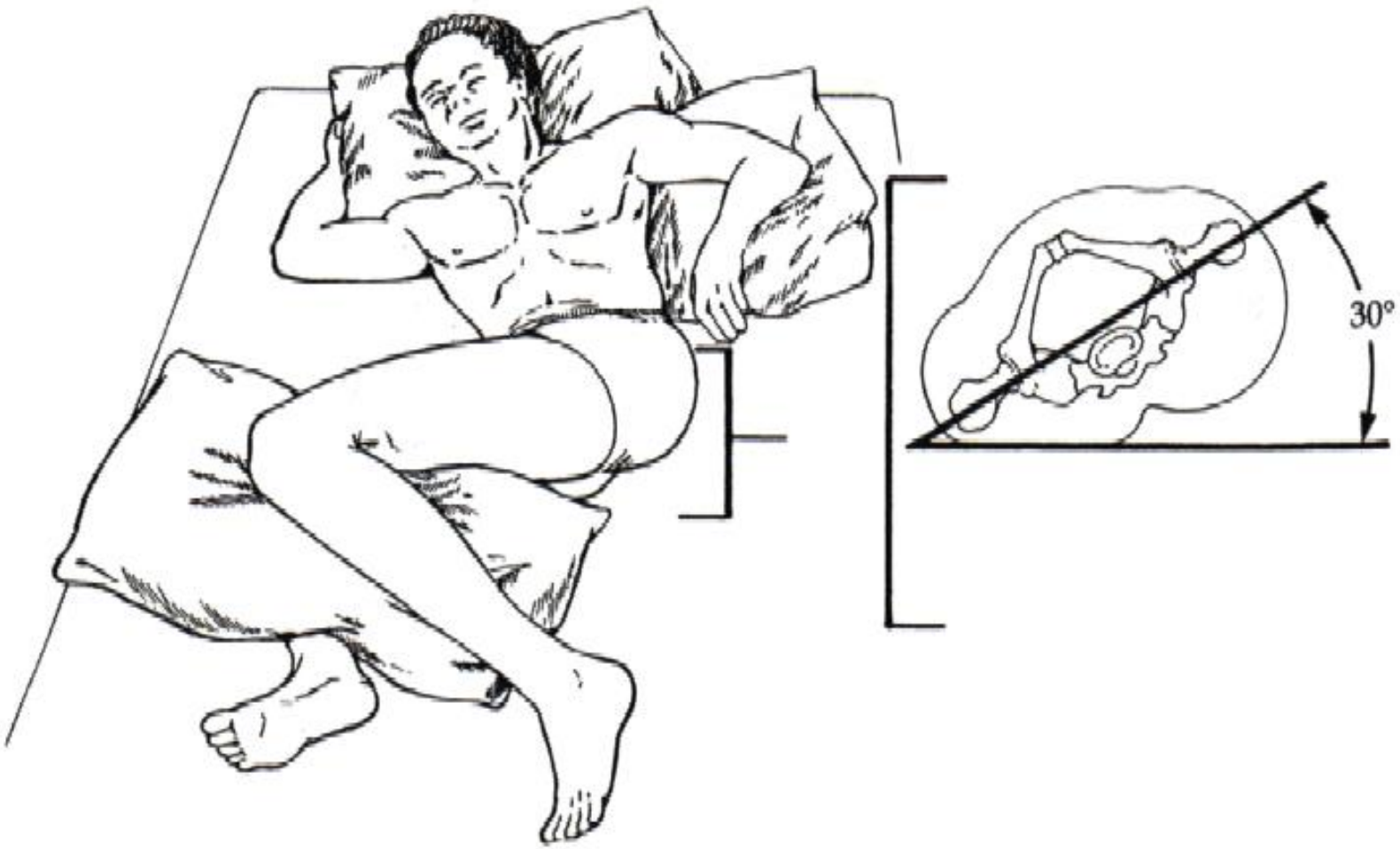
K - KEEP MOVING

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

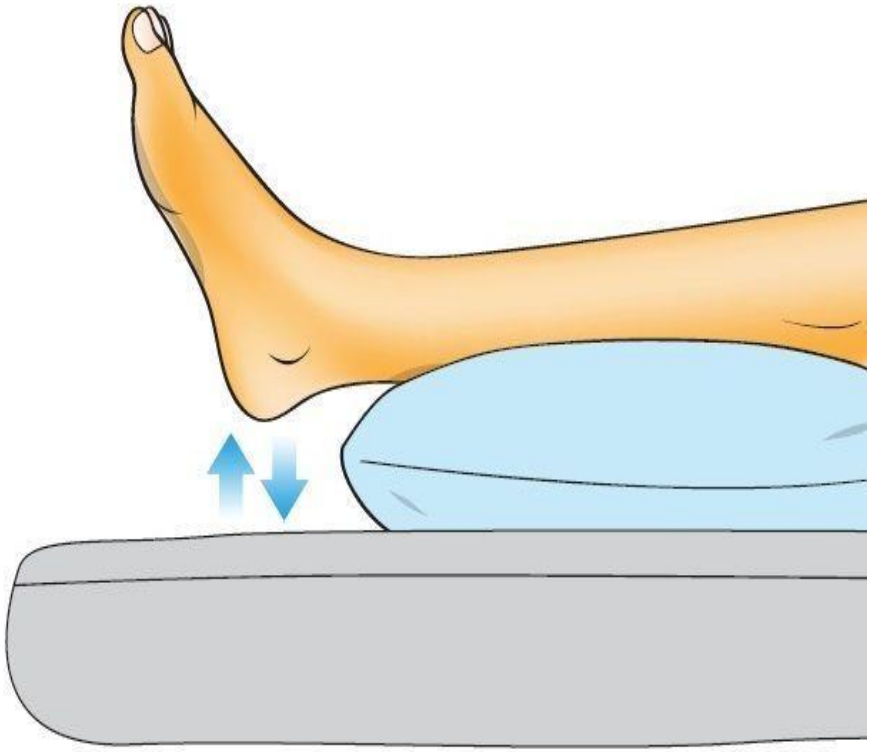
- Moving and regularly changing position relieves the pressure allowing the blood supply to return

- 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

I - Incontinence & Moisture

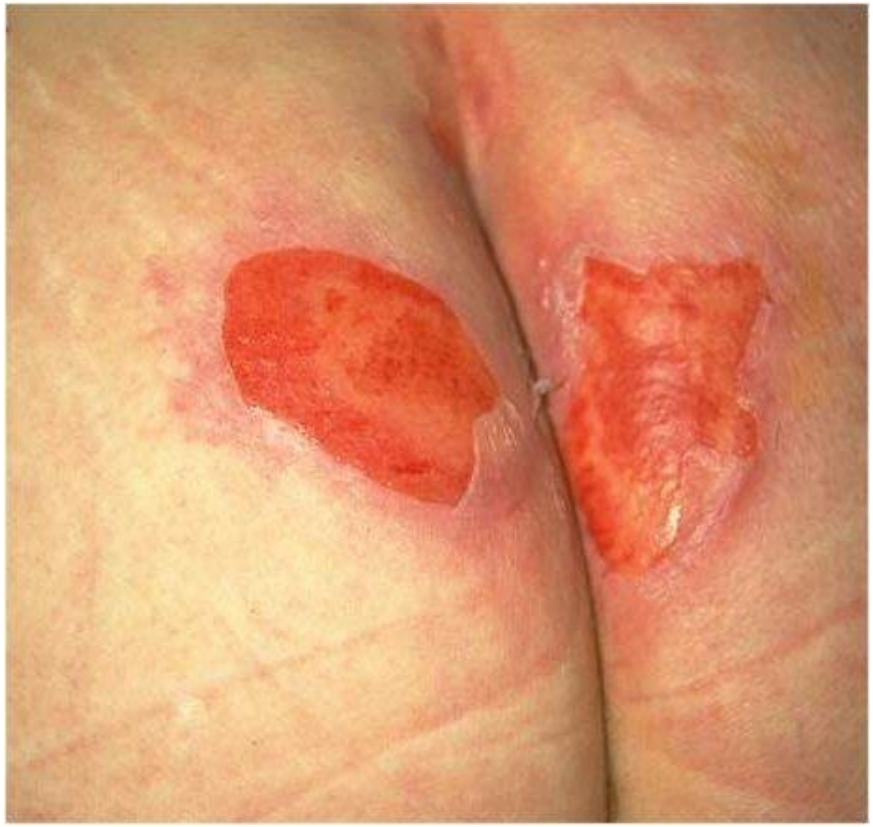
Moisture damage can occur to the skin by prolonged contact with moisture to the skin surface.

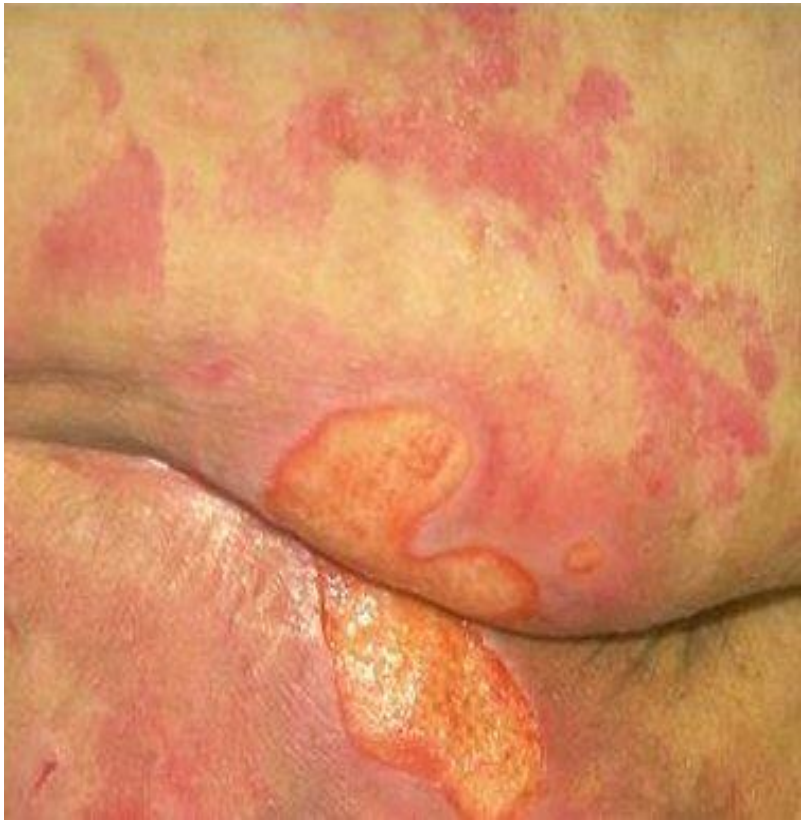
This can be in the form of sweat/ wound leakage /urine & faeces

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

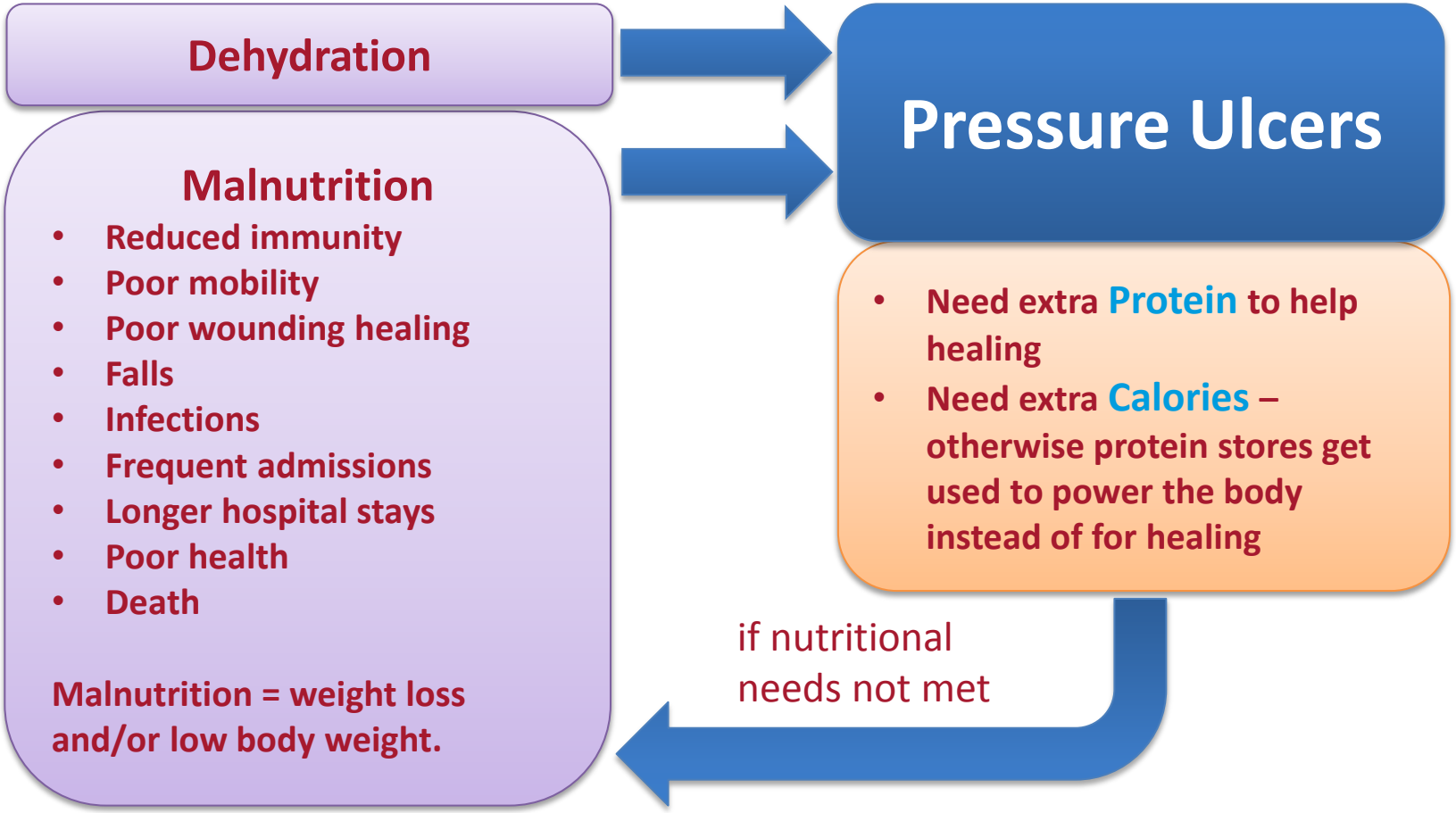
(page 21-22)

Moisture Lesions





N - Nutrition and Pressure Ulcers



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