TISSUE VIABILITY

AT RISK PATIENT

Harms – New or Existing
Pressure Ulcers, CAUTIs, VTEs, Falls

Pressure Ulcer

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

- European Pressure Ulcer Advisory Panel / National Pressure Ulcer Advisory Panel (2014)

Prevention is better (and less costly) than cure

Maintain skin integrity – intact skin will protect against infection

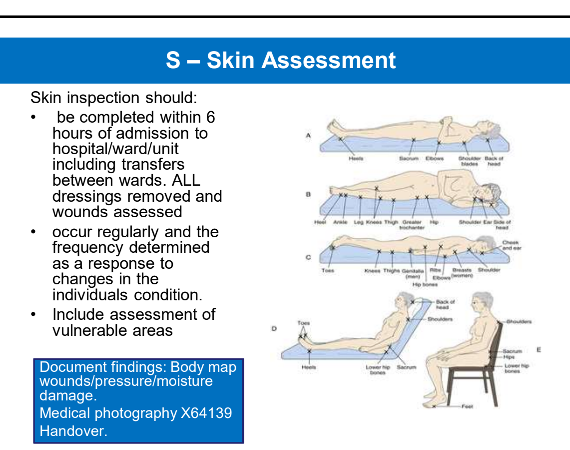
ASSKING

A	Assess Pressure Ulcer Risk (Waterlow for adults) and other risks
S	Skin assessment and skin care
S	Surfaces /Equipment
K	Keep moving/ Reposition
I	Incontinence
N	Nutrition
G	Giving information

S – Skin Assessment

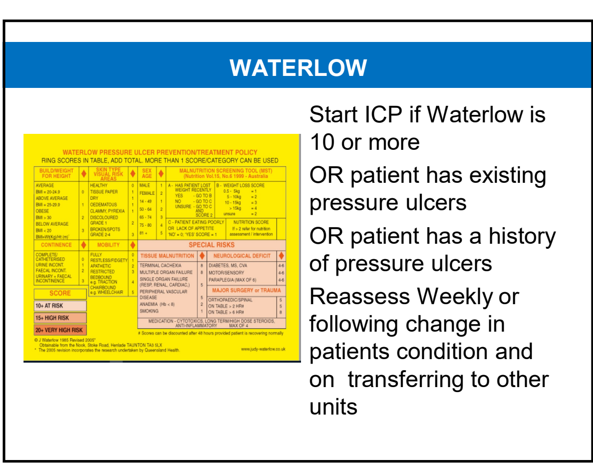
Skin inspection should:

- be completed within 6 hours of admission to hospital/ward/unit including transfers between wards. ALL dressings removed and wounds assessed
- occur regularly and the frequency determined as a response to changes in the individuals condition.
- Include assessment of vulnerable areas



Document findings: Body map wounds/pressure/moisture damage.
Medical photography X64139
Handover.

WATERLOW



WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY
RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

10+ AT RISK
15+ HIGH RISK
20+ VERY HIGH RISK

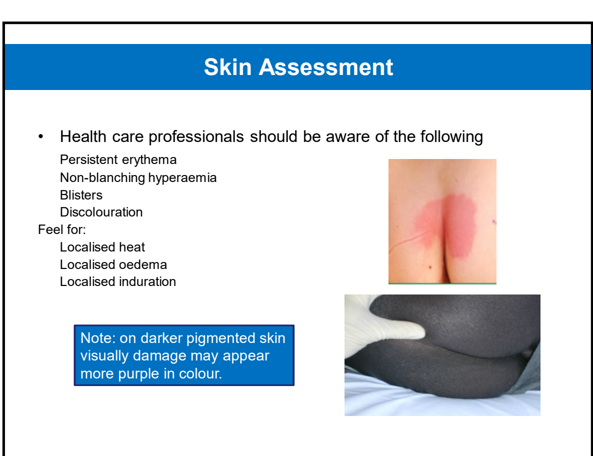
Start ICP if Waterlow is 10 or more

OR patient has existing pressure ulcers

OR patient has a history of pressure ulcers

Reassess Weekly or following change in patients condition and on transferring to other units

Skin Assessment

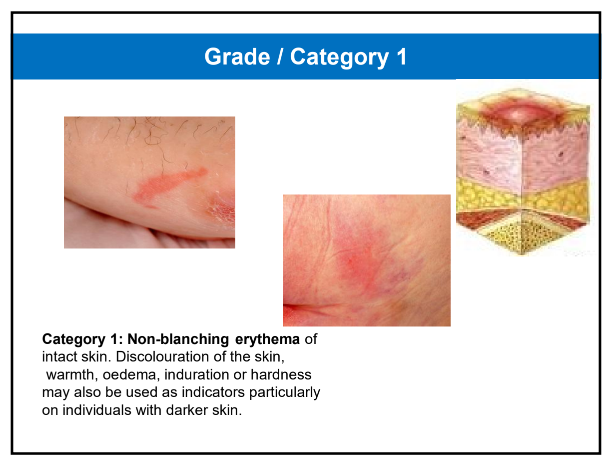


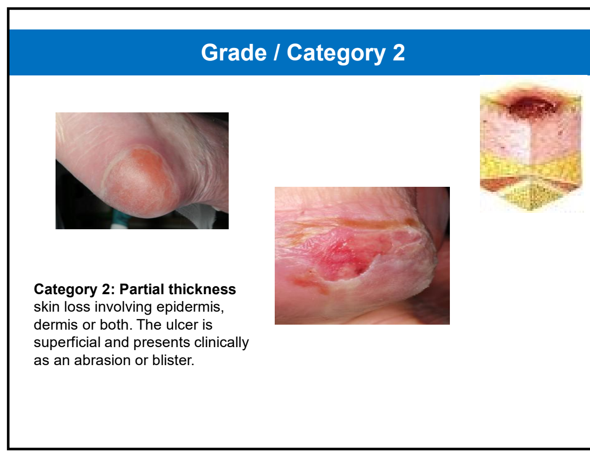
- Health care professionals should be aware of the following
  - Persistent erythema
  - Non-blanching hyperaemia
  - Blisters
  - Discolouration

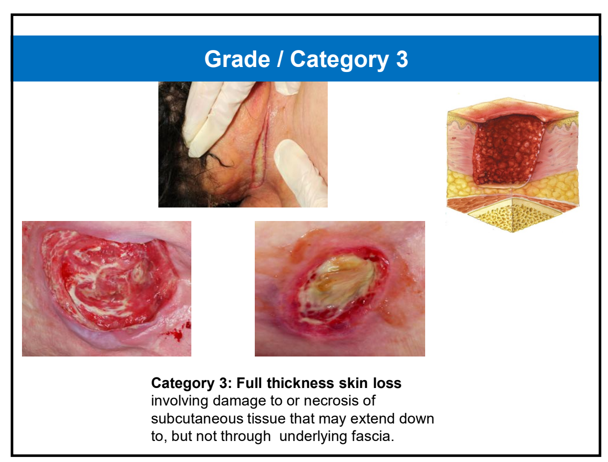
Feel for:

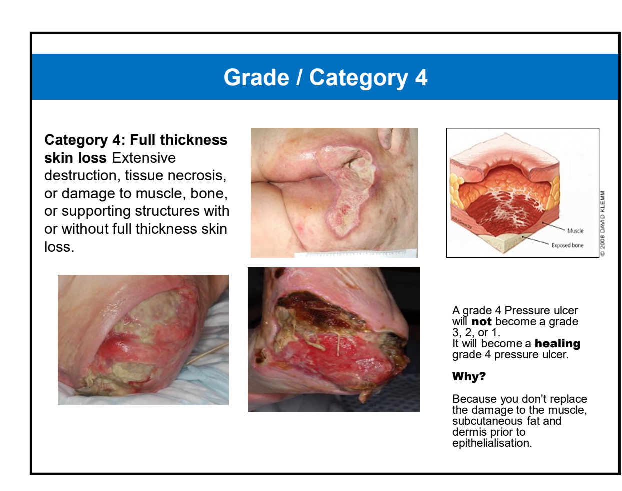
- Localised heat
- Localised oedema
- Localised induration

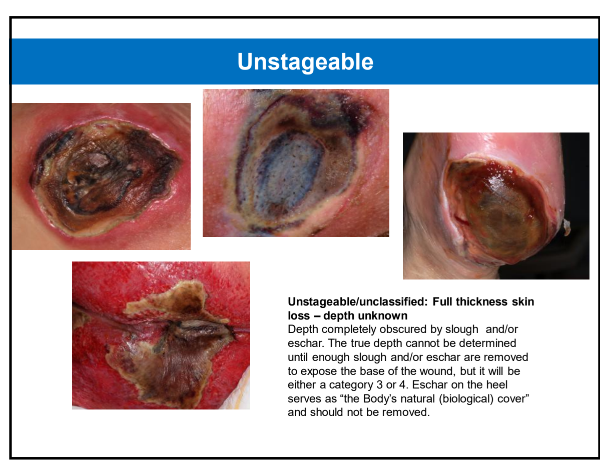
Note: on darker pigmented skin visually damage may appear more purple in colour.

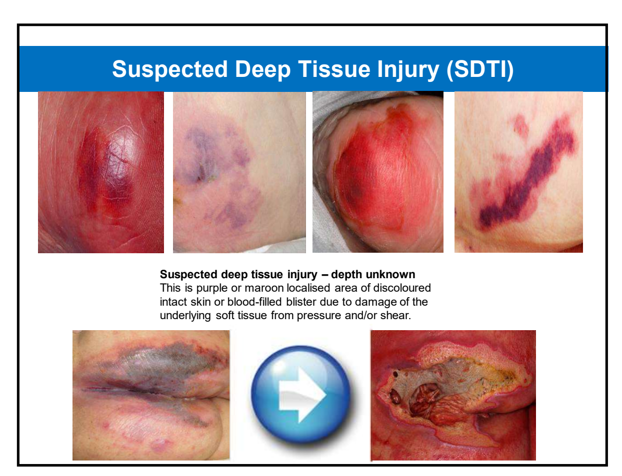

Grade / Category 1
Category 1: Non-blanching erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators particularly on individuals with darker skin.

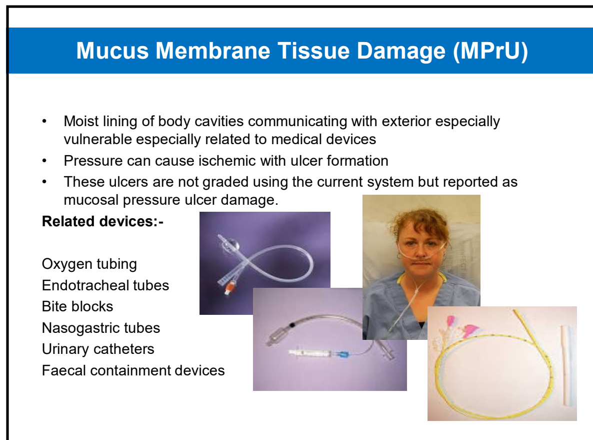

Grade / Category 2
Category 2: Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

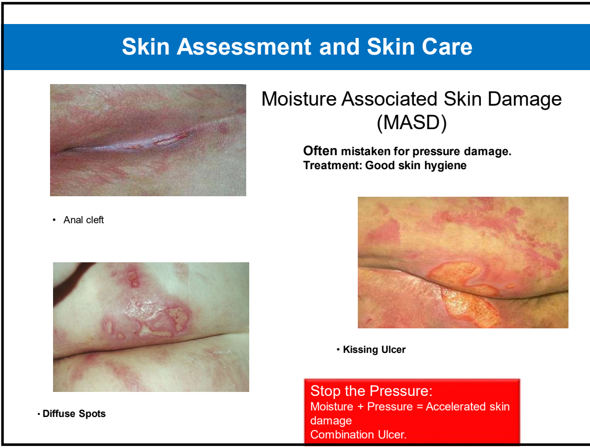

Grade / Category 3
Category 3: Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.


Grade / Category 4
Category 4: Full thickness skin loss Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.
A grade 4 Pressure ulcer will not become a grade 3, 2, or 1.
It will become a healing grade 4 pressure ulcer.
Why?
Because you don't replace the damage to the muscle, subcutaneous fat and dermis prior to epithelialisation.


Unstageable
Unstageable/unclassified: Full thickness skin loss – depth unknown
Depth completely obscured by slough and/or eschar. The true depth cannot be determined until enough slough and/or eschar are removed to expose the base of the wound, but it will be either a category 3 or 4. Eschar on the heel serves as "the Body's natural (biological) cover" and should not be removed.

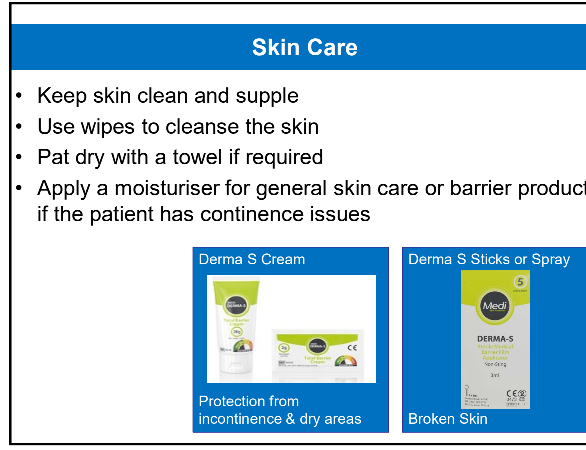

Suspected Deep Tissue Injury (SDTI)
Suspected deep tissue injury – depth unknown
This is purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of the the underlying soft tissue from pressure and/or shear.





PRESSURE ULCERS vs MOISTURE LESIONS

PRESSURE ULCERS	MOISTURE LESIONS
• Circular/ Regular shape	• Diffuse shape, may have several skin breaks
• Distinct edges	• May have irregular or jagged edges
• Pressure / shear present	• Moisture: urine, faeces, sweat, exudate
• Localised over Bony prominence, site of mucous membrane cavity or evidence of medical device	• Sites associated with moisture - Sacrum, skin folds, wound margins
• Can be deep	• Shallow
• Necrotic tissue can be present	• Necrotic tissue not present



K – Keep Moving

- Encourage mobility and self repositioning. Get patients up and out – good for mood, address any pain needs.
- Slide sheets or Hoist into chair – consider correct surface.
- Reposition as risk assessment guides e.g. 2, 4hourly - document
- Off loading of patients pressure areas with damage
- Liaise with other specialities /discharge planning
- Time spent in bed, off loading of pressure to vulnerable/ damaged areas.

I – Incontinence

Increased moisture on skin, accelerates skin breakdown and breeds bacteria. Urine and faeces burn the skin.

- Commence protecting skin with barrier cream before damage when patient is incontinent.
- Regular pad checks and repositions – correct sizing of pad. Only 1 pad is required
- Cleanse skin with aqueous cream dissolved in water.
- Complete documentation

N – Nutrition

Nutrition is key in wound healing and skin integrity.

- Encourage good diet and fluids.
- If poor intake/ patient at risk commence nutritional supplements.
- Ensure MUST assessment completed.

G – Giving information

- Communicating concerns with patient, relatives and MDT.
- Does the patient have capacity?
- Is the patient and relatives aware of the risks of pressure/tissue damage?
- Are they aware of the importance of the advised interventions?
- Are there safeguarding concerns?
- Escalate and document non concordance/ variations in care.
- Mental capacity assessment if non-concordant
- Pressure ulcer leaflet.

When to Report pressure ulcers on ULYSSES

All pressure ulcers and moisture damage must be reported

NB Check wound with senior nurse before instigating incident if uncertain of Category.

1. NEW pressure ulcers
2. Deterioration of a pressure ulcer – e.g. – category 2 increases to Category 3.
3. Existing pressure ulcers

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Known and previously reported pressure ulcers/ wounds do NOT need to be re-reported on admission to your area.

WOUND ASSESSMENT - TIME

- Wound assessment chart to document assessment of the wound and plan of care.
  (NB Only Pressure ulcers are categorised)

TIME

- T - Tissue
- I - Infection /Inflammation
- M - Moisture balance
- E - Edges
- Other considerations – e.g. Pain

IPC/TV Team Contact Details

- Oxford Road Campus
  0161 276 4042
  Tissue.ViabilityORC@mft.nhs.uk

SOME SUGGESTIONS FOR FURTHER READING / INFORMATION

- MFT eLearning packages on the hub for IPC & TV
- EPUAP/NPIAP websites
- Wounds UK website "Made Easy" Guides
- STOP THE PRESSURE website – Red dots
- React to red campaign
- Legs matter campaign
- WOUND CARE TODAY website
- Nursing Times & other journal websites
- Wound care product websites e.g. Convatec for information re dressings
- 3M Health Care Academy: Provided free to MFT staff To register, staff just need to put in email and Trust code which is LEARN132.
- Principles of best practice: Wound infection in Clinical practice 2016 consensus document
- NHS Improvement

Any Questions?