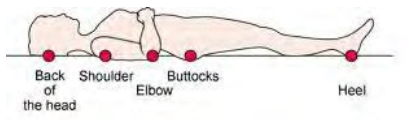
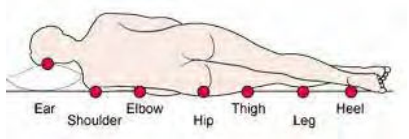
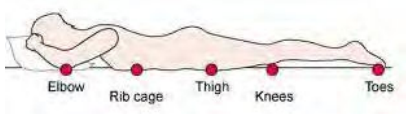
Section three
Skin

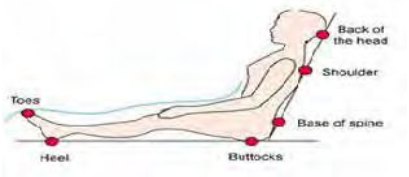
Check your skin daily for any discolouring, heat or broken areas which are signs of pressure damage.

The areas marked on the diagram are the areas most at risk. If you notice any damage, report it to a healthcare worker.









Taken from the patient information website of Cancer Research UK: www.cancerresearchuk.org

Contacting local health services

If you want to make a comment about this service or need some advice or information about this or any other local NHS service, please contact:

NSCP Patient Advice & Liaison Service (PALS)
Freephone: 0800 389 5260
Email: nscp.pals@nsomersetcp-cic.nhs.uk

Care Quality Commission (CQC)
The quality of our service provision is monitored by the Care Quality Commission (CQC). For further information please visit: www.cqc.org.uk

Dignity in Care Campaign
The Dignity in Care Campaign aims to put dignity at the heart of care services in North Somerset. For further information please visit: www.northsomerset.nhs.uk/dignity

NHS Direct
If you are concerned that your child is unwell, please telephone NHS Direct on 111.

Social Care
If you are concerned that a child is being harmed or is at risk of abuse or neglect, please telephone Social Care on 01275 888 266.

NSCP services may occasionally be unavoidably unavailable due to severe weather, staff sickness or other events outside of NSCP control.

NSCP/006/009/001/001/001/0215

NSCP

SPECIALIST SERVICES

Tissue Viability Service

Pressure ulcers

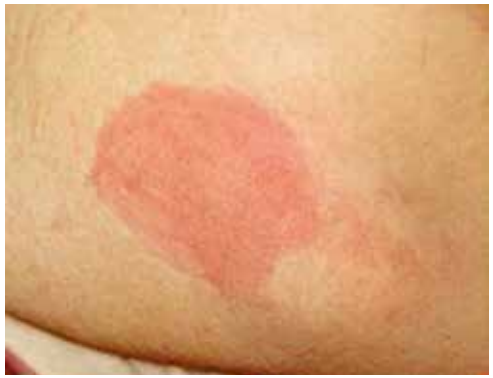
Are you or someone you care for at risk of pressure ulcers?

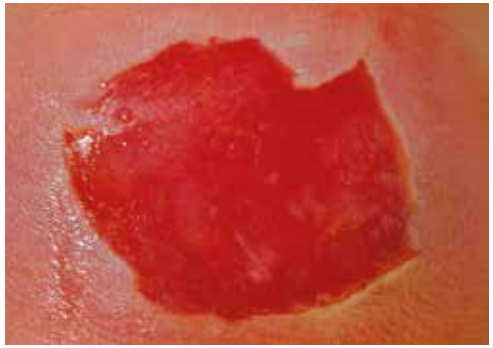
What is a pressure ulcer?

- Do you have a health condition which limits your mobility or affects your blood supply?
- Are there areas of your body you cannot feel?
- Do you have a poor appetite?
- Are you incontinent?
- Do you spend a long time in bed or in a wheelchair?

If you have answered yes to one or more of the above you may be at risk of developing pressure ulcers.

Two out of three people with pressure ulcers are over 70





Areas which are red or discoloured can deteriorate rapidly into significant wounds. Red marks which do not disappear in 20-30 minutes need **prompt** action!

Pressure ulcers are wounds caused by continuous pressure.

Keep moving:

- Change your position regularly
- If you are in bed you need to change your position at least every two hours
- If you are in a wheelchair or seated you are more at risk and you need to change your position more frequently.

Eat a good diet:

If you have a reduced appetite, eat small but frequent meals and ensure you drink at least eight cups of fluid each day. If you are incontinent, ensure you keep your skin clean and dry.

If the area remains red or you notice blisters or broken areas, this is likely to be an early pressure ulcer and must be reported to your healthcare professional.

If you have darkly pigmented skin it is much more difficult to see these changes. If you notice pain heat or any discolouration in an area where bones are close to the skin, please report this to your healthcare professional.

If you have difficulty checking your skin, or you have any queries or concerns about pressure ulcers, please contact your healthcare professional:

My healthcare professional is:

Telephone:

Contacting local health services

If you want to make a comment about this service or need some advice or information about this or any other local NHS service, please contact:

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NSCP

SPECIALIST SERVICES

Tissue Viability Service

Inspecting your skin

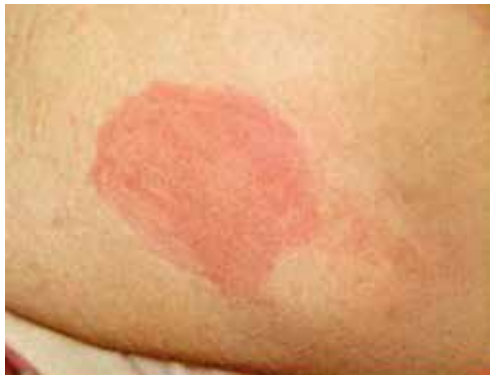
Leaflet 2

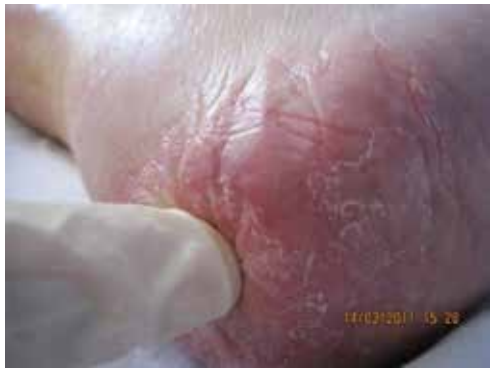
What is a pressure ulcer?

A pressure ulcer is any wound caused by unrelieved pressure. It is sometimes called a bed sore, but this can be misleading, as they do not always occur whilst in bed.

Pressure ulcers are serious wounds and are preventable if caught and treated at an early stage.

You have been identified as being at risk of developing a pressure ulcer. This leaflet has been written to guide you or your carer through the process of inspecting your skin. This will ensure the ulcer is identified and reported before it develops into a serious wound.





Common places for pressure ulcers to develop

The most common places for pressure ulcers to occur are over the area where bones are close to the skin, this may include the heels, ankles, knees, the bottom, base of spine, hip, elbow and shoulders. They can develop when lying in bed and when sitting in a chair or wheelchair.

Check your skin condition

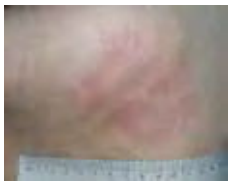
It is important to have your skin checked daily as redness or heat can indicate skin damage. If you notice a red area on an area where the bone is near the skin, apply gentle pressure with your finger for about 10 seconds. If the area blanches (turns white) this has not developed into a pressure ulcer.

Pressure Ulcer Categorisation

Pressure ulcer categorisation chart

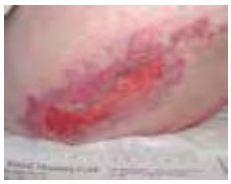
Adapted from EPUAP/NPUAP 2009

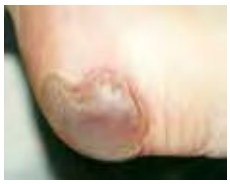
Superficial



EPUAP – Category 1

- Non-blanchable erythema of intact skin: persistent redness in light pigmented skin.
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple.
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).



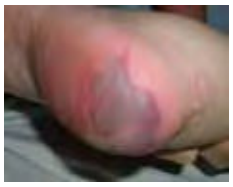


EPUAP System – Category 2

- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising*
- Check for moisture lesion.
- May have light slough but wound bed visible.

* Bruising appearance and blood filled blister would indicate deep tissue injury.

Deep

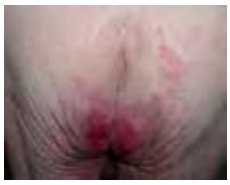


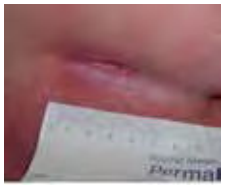
EPUAP – Category 3

- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunnelling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep grade 3 pressure ulcers.
- Bond/tendon is not visible or directly palpable.
- If actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) assess whether debridement is appropriate. State category if altered when enough slough is removed to expose the base of the wound, until this point the true depth cannot be determined; but it will be either grade 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance) should only be debrided, once full assessment undertaken and agreed safe and appropriate to do so.. Should be documented as grade 3 until proven otherwise.

EPUAP – Category 4

- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunnelling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus **do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow.**
- Grade 4 ulcers can extend into the muscle and/or supporting structures (eg fascia, tendon or joint capsule).





Moisture Lesions

- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.

Acknowledgement to Midlands and East NHS for this information and images.

Waterlow

WATERLOW PRESSURE ULCER PREVENTION / TREATMENT POLICY

NSCP

Name …… NHS Number…… Date……..

USE GRID UNDERNEATH WATERLOW TO INDICATE SCORING, ADD TOTAL.

MORE THAN 1 SCORE/CATEGORY CAN BE USED

Re-evaluation required (weekly / monthly).....

Build / weight for height		Skin type visual risk areas		Age		Malnutrition screening tool		
Average BMI		Healthy	0	14-49	1	A - Has patient lost weight recently		B - weight loss score
20-24.9	0	Tissue paper	1	50-64	2	Yes - go to B		0.5-5KG 1
Above average BMI		Dry	1	65-74	3	No - go to C		5-10KG 2
25-29.9	1	Oedematous	1	75-80	4	Unsure - go to C and score 2		10-15KG 3
Obese BMI >30	2	Clammy, pyrexia	1	81+	5			> 15 KG 4
Below average BMI		Discoloured						Unsure 2
< 20 BMI	3	Grade 1	2					
		Broken/spots						
		Grade 2-4	3					
				Gender		C - Patient eating poorly or lack of appetite		NUTRITION SCORE NOTE:
						No	0	If >2 refer to GP for nutrition
				Male	1	Yes	1	assessment / intervention
				Female	2			

Continence		Mobility		Special risks					
Complete /		Fully	0	Tissue malnutrition		Neurological deficit		Major surgery / trauma	
catheterised	0	Restless / fidgety	1	Terminal cachexia	8	Diabetes, MS, CVA	4-6	Orthopaedic / spinal	5
Urine incontinence	1	Apathetic	2	Multiple organ		Motor / sensory	4-6	On table > 2 hours	5
Faecal		Restricted	3	failure	8	Paraplegia (Max of 6)	4-6	On table > 6 hours	8
incontinence	2	Bedbound		Single organ failure					
Urinary and faecal		e.g. traction	4	(resp / renal /		Medication:		Scores can be discounted after	
incontinence	3	Chairbound		cardiac)	5	Cytotoxics		48 hours provided patient is	
		e.g. Wheelchair	5	Peripheral vascular		Long term / high dose steroids	4	recovering normally.	
				disease	5	Anti-inflammatory, Max of 4			
				Anaemia (Hb < B)	2				
				Smoking	1				

At risk	High risk	Very high risk
10+ follow: PROMPT Green SOP 1	15+ follow: PROMPT Amber SOP 2	20+ follow: PROMPT Red SOP 3

Reassessment chart

Date	Build / weight for height	Visual skin type	Gender / age	MUST	Continence	Mobility	Special Risks	Total score

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NSCP/006/009/022/002/1016 Chief Executive Judith Brown, Chair Linda Nash Company registration Number 07569496

Tissue Viability Green

NSCP

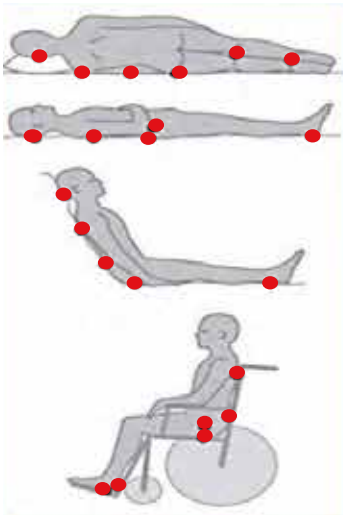
Pressure needs prompt action

Identified as at risk:

Pressure points
Red – report it
Oral intake
Moisture
Posture
Take pressure off

Green PROMPT card

www.nscphealth.co.uk



Taken from the patient information website of Cancer Research UK: http://www.cancerresearchuk.org

Action for identified at risk

NSCP

P = Pressure points
Inspect the areas of skin which are near to the bone as often as your nurse suggests, which will be at least once a week.
R = Red – report it
Report at once any painful areas and new red marks which do not disappear after 20–30 minutes.
O = Oral intake
It is important to eat a balanced diet and drink plenty of fluids. Seek advice PROMPTLY if this is not possible.
M = Moisture
Keep the skin clean and dry. Use barrier cream if needed.
P = Posture
Be aware of your posture. If your position is causing pain on the areas of skin close to your bones seek assistance. Poor posture can contribute to the development of pressure ulcers.
T = Take pressure off
Keep as active as possible and build small changes of position into your routine. If you are unable to do this pressure relieving aids may be needed. Please contact your nurse.

Pressure ulcers are serious wounds and skin can quickly break down.

Seek advice PROMPTLY if unsure call.....

NSCP/006/009/021/001/1014

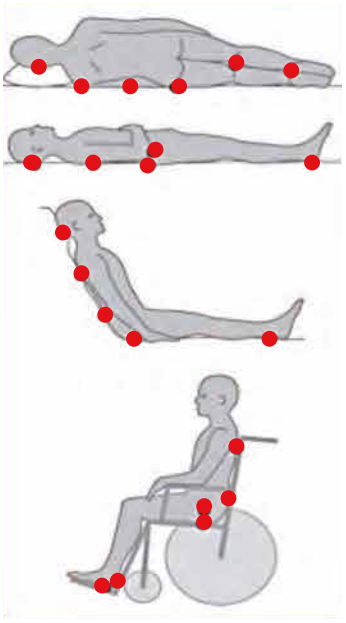
Tissue Viability Amber

NSCP

Pressure needs prompt action

Identified as at high risk:

Pressure points
Red – report it
Oral intake
Moisture
Posture
Take pressure off



Taken from the patient information website of Cancer Research UK: http://www.cancerresearchuk.org

Amber PROMPT card

www.nscphealth.co.uk

Action for identified at high risk

NSCP

P = Pressure points
Inspect the areas of skin which are near to the bone as often as your nurse suggests which will be at least three times a week.
R = Red – report it
Report at once any painful areas and new red marks which do not disappear after 20–30 minutes.
O = Oral intake
It is important to eat a balanced diet and drink plenty of fluids. Seek advice PROMPTLY if this is not possible.
M = Moisture
Keep the skin clean and dry. Use barrier cream if needed.
P = Posture
Be aware of your posture. If your position is causing pain on the areas of skin close to your bones, seek assistance. Poor posture can contribute to the development of pressures ulcers.
T = Take pressure off
Change position every two to four hours. If you are unable to do this pressure relieving aids may be needed. Please contact your nurse.

Pressure ulcers are serious wounds and skin can quickly break down.

Seek advice PROMPTLY if unsure call.....

NSCP/006/009/020/001/1014

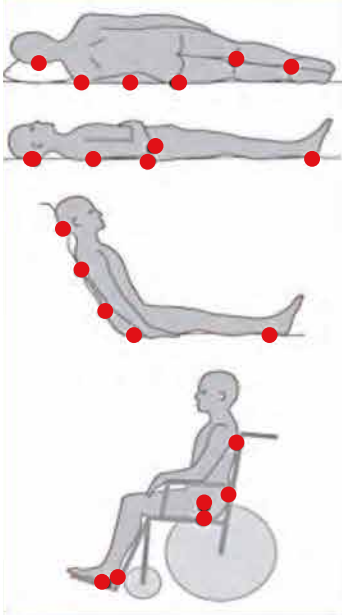
Tissue Viability Red

NSCP

Pressure needs prompt action

Identified as at very high risk:

Pressure points
Red – report it
Oral intake
Moisture
Posture
Take pressure off



Taken from the patient information website of Cancer Research UK: http://www.cancerresearchuk.org

Red PROMPT card

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Action for identified at very high risk

NSCP

P = Pressure points
Inspect the areas of skin which are near to the bone as often as your nurse suggests, which will be at least once daily.
R = Red – report it
Report at once any painful areas and new red marks which do not disappear after 20–30 minutes.
O = Oral intake
It is important to eat a balanced diet and drink plenty of fluids. Seek advice PROMPTLY if this is not possible.
M = Moisture
Keep the skin clean and dry. Use barrier cream if needed.
P = Posture
Be aware of your posture. If your position is causing pain on the areas of skin close to your bones seek assistance. Poor posture can contribute to the development of pressure ulcers.
T = Take pressure off
Change position at least every two hours. If you are unable to do this, pressure relieving aids may be needed. Please contact your nurse.

Pressure ulcers are serious wounds and skin can quickly break down.

Seek advice PROMPTLY if unsure call.....

NSCP/006/009/019/001/1014

Wound Classification

Incontinence Associated Dermatitis (IAD) (Moisture Lesions)	*Tick box if present*	Signs and Symptoms	*Tick box if present*	Pressure Ulcer
• Moisture must be present (e.g. shiny, wet skin caused by urinary incontinence or diarrhoea)		Cause		• Pressure and/or shear friction/moisture present
• Natal cleft/Inner gluteal/buttocks/any skin fold • IAD may occur over a bony prominence. (If this appears to be the case, exclude pressure shear and friction prior to diagnosis)		Location		• Over a bony prominence or aligned with causative pressure
• Mirror image and linear in shape (splits in skin) • Diffuse, in several superficial spots		Shape		• Takes the appearance of the causative pressure • Limited to one spot or specific area
• Superficial		Depth		• Superficial or deep
• No necrosis		Necrosis		• A black necrotic scab on a bony prominence
• Diffuse or irregular edges		Edges		• Distinct edges
• Non uniform redness • Blanchable or non-blanchable erythema • Pink or white surrounding skin due to maceration		Colour		• Uniform redness • If redness is non-blanchable, this indicates damage to the capillaries

Moisture damage will improve rapidly *(e.g. 48-72 hrs)*. Pressure Ulcers will improve more slowly *(e.g. usually longer than 7 days)*. If the area occurs over a bony prominence it is more likely to be a Pressure Ulcer.

Trigger Tool to Support Prevention of Pressure Ulcers

Has the patient deteriorated in health?	
Has the patient lost weight?	
Is the patient eating and drinking?	
Has the patient's mobility decreased?	
Has the patient developed a new incontinence problem?	
Is the patient palliative?	

Medi Derma-S Barrier Cream

Application Instruction for **Medi Derma-S** Barrier Cream

Patient Name: .....

Date of Instruction: .....

This patient has had a skin inspection and assessment. To prevent moisture damage to the skin, **Medi Derma-S** barrier cream should be applied sparingly. Use the guide below to get the best results.

Location: .....

Frequency of Application: .....

Duration of Treatment: .....

.....

Name of Nurse: ..... Signature: .....

Contact No.: .....

Information for Use Guide

Skin Preparation:

- Ensure that the skin around the treatment area is clean, free from any grease and dry.

Application:

- **"Pea to Palm".** Use a pea sized amount of cream to cover an area approximately the size of your palm.
- Using a gloved finger tip, apply evenly to the treatment area using a circular motion.

Quantity to Use:

- **Do NOT over-apply.** The skin should be clearly visible through the cream layer.
- If the skin appears oily, too much cream has been applied. Remove excess with a soft paper tissue/towel.

Apply Dressing/Device:

- Once you are happy that the correct amount of cream has been applied and is fully dry, apply the dressing, pouch or adhesive device as normal (if applicable).

  Re-apply barrier cream as instructed.

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