Pressure and Shear

A pressure ulcer is defined as 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 sheer (NPUAP, EPUAP 2014)
The size of the problem - do we know?

1977 8.8% acute & community prevalence (Barbanel)

1991 6.7% prevalence rate (DOH)

1993 prevalence range 2.7% - 42.7% (DoH)

2009 0.74%/1000 population (Bradford) (Vowden & Vowden)

2012 Safety Thermometer 5.39% (G’s 2 to 4) = 8833 people in 477 organisations
The North Region Picture

Data extracted from the Strategic Executive Information System (STEIS) on 4/1/16, subject to variation if any reported incidents are subsequently de-logged.
NHS Safety Thermometer
National Data Report 2014-15

NHS Safety Thermometer at a glance

6,610,491
PEOPLE SURVEYED

1,156
ORGANISATIONS COLLECTING DATA

4.5%
PRESSURE ULCERS

0.7%
FALLS WITH HARM (In the last 72 hours in a care setting)

0.3%
URINE INFECTIONS (In patients with a catheter)

0.3%
NEW VTE

‘Harm free’ care 93.9%

www.safetythermometer.nhs.uk
The cost of the problem?

The total cost in the UK estimated to be £1.4 billion to £2.1 billion annually (4% of total NHS expenditure) Bennett et al 2004
The Cost - Category 1

from

• £1,1214

(Dealey et al 2012)
The Cost - Category 4

To

• £14,108

(Dealey et al 2012)
The Cost to the Patient

- Can be life threatening
- Can lead to severe disabilities/amputation
- Infection and osteomyelitis
- Extended hospital stays
- The need for surgery or prolonged immobility
- Along with exudate and leaking dressings, possible malodour and embarrassment but most importantly **pain and suffering**
Safeguarding and Neglect:
Avoidable v’s Unavoidable
Avoidable

The person providing care did not:

- Evaluate the patient's clinical condition and identify pressure ulcer risk factors
- Plan and implement interventions consistent with the patients needs and goals and recognised standards of practice
- Monitor and evaluate the impact of the interventions and revise the interventions as appropriate
- Reasons for refusing care have not been explored and risks not adequately explained
Unavoidable

• A pressure ulcer developed despite the care provider evaluating the patient's clinical condition and pressure ulcer risk factors and developing an appropriate preventative plan of care
• Monitoring and evaluating the impact of the interventions and revising the intervention as appropriate
• The patient or carer chose not to adhere to the prevention strategies despite being fully informed of the possible consequences
Pressure Ulcer Safeguarding Protocol

PU Prevention Summit
1st February 2016

Cathy Burke
Nurse Consultant Safeguarding

&

Jackie Wainwright
Associate Designated Nurse for Safeguarding Adults

South Yorkshire & Bassetlaw: Pressure Ulcer Reference Group

THE NHS CONSTITUTION
the NHS belongs to us all
South Yorkshire & Bassetlaw Pressure Ulcer Good Practice Protocol for Safeguarding

WHY

WHAT

HOW
The protocol provides guidance for staff in all service sectors in the South Yorkshire & Bassetlaw area who are concerned that:

‘A pressure ulcer (or other forms of skin damage) may have arisen as a result of poor practice, neglect, acts of omission or deliberate harm and therefore have to decide whether to make safeguarding alert in line with the local multi agency Safeguarding Policy and Procedures’.

Prompting transparency within multi-agency partnership approach to safeguard and protect from harm people who are or become vulnerable.

(The Care Act 2014)
This protocol should be used to decide whether to make a safeguarding alert and if applicable, report as a serious incident requiring investigation in respect of pressure ulcer care.
Safeguarding Adult Principles

- Protection
- Prevention
- Empowerment
- Proportionality
- Accountability
- Partnership
Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004

Working together to safeguard children

A guide to inter-agency working to safeguard and promote the welfare of children

March 2015
Safeguarding Considerations

- For all PUs
- Not all Grade 3 & 4 meet safeguarding thresholds
- Patients are empowered – engaged with all aspects of the safeguarding process
- Listen & act on their wishes
- Root Cause Analysis
- Safeguarding identified: alert following local procedures
- Sharing and learning of lessons
Safeguarding Considerations

• Indicates Avoidable PU = make a Safeguarding (Alert) Referral

• Investigation will identify if this was a result of abuse or neglect.

• Has this happened in isolation?

• Other forms of abuse evident?
Root Cause Analysis
Root Cause Analysis

Well recognised method of investigation

- Lessons learnt
- Gathering and mapping information
- Identifying care and service delivery problems
- Analysis to identify contributory factors and root causes
- Generating solutions
- Recommendations, action plan and report

(National Patient Safety Agency)
If ill treatment or wilful neglect is suspected at any stage this should be reported to the police.

Step 1: EVENT
Pressure Ulcer Grade 3 or 4 detected in a patient

Step 2: REPORT
Using local incident reporting system.

*Step 3: REVIEW
Using Root Cause Analysis tools, determine if this is avoidable or unavoidable. If avoidable it should be reported routinely as a safeguarding concern.

Step 4: Is this a safeguarding alert?

Yes
- Complete and send safeguarding alert using your local safeguarding procedures. For grade 3 and 4 a serious incident report should have been made.

- Safeguarding process initiated
- Local Investigation initiated
- Regular Communication maintained

Report(s)/response produced & actions identified

AND
Consider level and type of investigation(s) required and agree these, response methods and timescales

Yes

Has a safeguarding concern been identified following further investigation

No

Follow organisational policies and procedures to progress type of report as above

Actions implemented, lessons learnt and shared. Refer to Regulator/ISA if appropriate

Normal Policy applies
Cost & Impact

NHS
✓ Financial
✓ Capacity
✓ Resources
✓ Public Image
✓ Reputation

Patient
✓ Harm: Pain & Discomfort
✓ Psychological
✓ Social
✓ Quality of life
✓ Loss of some function
✓ Permanent Scaring
✓ Death
Safeguarding: Integrated Response

• Interagency working

• Home Care

• Care Homes

• District Nursing

• Social Care

• Investigation & Safeguarding Responses
Key Drivers

Safeguarding children and young people: roles and competences for health care staff
INTERCOLLEGIATE DOCUMENT
Third edition: March 2014

Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004

Every Child Matters
Change For Children

Transforming care:
A national response to Winterbourne View Hospital
Department of Health Review:
Final Report

'Harmfree'care
Summary of this guidance

- Support Professional Decision Making
- Pressure Ulcers
- Need to Assess & Investigate
- Transparency

Multi-agency Approach:
- Determine if this needs reporting as a safeguarding incident through local safeguarding board procedures.
REACT TO RED
The Bassetlaw Journey

Denise Nightingale
Chief Nurse.
The Commissioning Conundrum

- What do we know about our providers?
- Quality Assurance – where to look?
- Contracts versus relationships and support?
- Who’s accountability is it?
Bassetlaw History

• 6 years of CQUINs
• Patient Concerns
• System Transparency
• Use of non recurrent re-ablement monies.
How to ‘guide’

• Build a system around the ‘place’.
• Recognise commissioner role and advantages of clinical commissioning.
• Equality of care and services for the most vulnerable.
• Measure improvement.
Where are we now?

- React to red
- Care Home Barometer (QiF)
- Care Home Forum
- End of Life/Nutrition initiatives
- Sepsis identification
- MRSA eradication programme
- Bassetlaw IPC tool.
BHP Care Home Project

- Geri Reevell - Tissue Viability Specialist Nurse
- Tessa Anders - Tissue Viability Nurse
- Simone Ritchie - Trainee Assistant Practitioner
Statistics’

• 20% of residents in residential and nursing homes will develop pressure ulcers (NPSA; 2010)

• 60% at risk (Callaghan; 2014).
Can we come in?

Where we were
March 2012
Education and Training

February to December 2013

232 staff from 18 homes were trained
The size of the problem...

28 Care Homes

- Total staff.............1144
- Total residents.........1129
So what was the problem....

• Lack of knowledge about pressure ulcer prevention and management from care home staff - 47% of those trained in Bassetlaw had never received any previous pressure ulcer prevention training

• Staff unable to recognise a pressure ulcer until severe
Cont...

- Staff unable to be released from the home to attend training
- Lack of confidence from care home staff
- Low morale in care homes when pressure damage identified
- Desire from care home staff to do their best for their residents
Meet and Greet
Link Champions

- Current 40-50 attendees from 28 care
If he has a bedsore, it’s generally not the fault of the disease, but of the nursing”

### Pressure Ulcer Prevention

#### Training Pack for Care Homes

**Surface**

- Identifies resident at risk and understands what pressure relieving equipment is needed.
- Understands and can follow the guide for the prevention of support surfaces (page 12).
- Demonstrates an awareness of how to check that equipment is working and is well maintained (Settings, faults, bounce, firmness and contamination).
- Knows how to report faulty equipment and who to.

**Incontinence & Moisture**

- Understands the damage urine, faeces, sweat and wound leakage can cause.
- Understands how to prevent moisture damage.
- Understands how to use barrier products and when.
- Shows an awareness of continence products and how to use.
- Promotes regular toileting.
- Knows how to report and to who, any concerns, dribbling urine, concentrated urine and loose

**Skin Inspection**

- Is able to identify BESTSHOT pressure areas to check, and how often.
- Is able to perform Best Test and understands the results.
- Knows how to report and to who, any areas of redness or broken skin.
- Is able to document accurately and in a timely manner.
- Understands preventative measures that will require implementing.

**Nutrition & Hydration**

<table>
<thead>
<tr>
<th>Overall Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Assessor:</td>
</tr>
</tbody>
</table>

The above result has been discussed with me and advice has been given.

| Signature of Trainer: | Date: |

---

**K Keep Moving**

- Identifies who needs a repositioning schedule.
- Understands the need for regular repositioning.
- Can implement a good, resident specific, repositioning schedule.
- Awareness of the different techniques for repositioning and off-loading, including slabs and oxygen tubing (Slides, 30 degree lift, slide sheet, pressure relieving boots).
THE NEXT STEP…
Recognise & Reward the Care Homes
The CHASE
Care Home Achievement Success Event

In partnership with:

Nottinghamshire Healthcare NHS Foundation Trust
CHASE WINNERS’
Link Champion Feedback

• “We have placed posters around the home regarding a pressure relieving products, and staff have now ordered these as there knowledge base has been enhanced and confident in using this product” – Victoria Care Home

• The Link Champions in Cherry Holt have instigated that all residents have their weight and mattress setting on a visible laminated chart in their room.

• A Link Champion challenged a Community Nurse on how to perform the blanching test and because she did this it prevented an incorrect reporting of a pressure ulcer.
Achievements

• Greater confidence from care home staff in:
  ① Terminology
  ② Early recognition of pressure damage
  ③ Improved use of equipment

• Link champions taking ownership and developing their ideas
• Improved documentation within care home setting
• Increased pride from staff
World Stop the Pressure Day 2015
And Finally…

55% Reduction in Pressure Ulcers in 12 months
Collecting Data & the Benefits......

- Inherited
- Acquired Unavoidable
- Acquired Avoidable
Residential Homes

Residential - Newly Acquired **Avoidable**

- May-15: 1
- Jun-15: 3
- Jul-15: 3
- Aug-15: 2
- Sep-15: 1
- Oct-15: 1
- Nov-15: 1
- Dec-15: 1

**Residential: Newly Acquired Avoidable**
Nursing Homes

Nursing - Newly Acquired **Avoidable**

- May-15: 2
- Jun-15: 1
- Jul-15: 0
- Aug-15: 0
- Sep-15: 0
- Oct-15: 0
- Nov-15: 0
- Dec-15: 0

**Nursing: Newly Acquired Avoidable**
Clumber Court Care Home – Eileen Ward, Care Manager

IMPACT OF REACT TO RED
How it affects us all
Who needs to be part of React to Red in a Care Home?

When the implementation of the React to red DVD commenced in 2015 the initial reaction is to the Nurses and Care staff.
Who Else?

We took it a step further and have rolled the DVD out to all staff that have resident contact, or are part of the “care” team, that means our Kitchen Team, Housekeeping and Maintenance team are all involved.

Agency staff that we may require are also included in the training programme.
What is the impact on the Home and Team
Impact from a CQC view point

**Are we Responsive** - Responsive of the care requirements
improves with staff knowledge

**Are we Effective** - Staff effectiveness improves, the homes
effectiveness is monitored externally by the TVN support team

**Are we Safe** - The Home is safer as a result, fewer
Notifications and Safeguarding referrals, fewer pressure incidents.

**Do we Care** - Confidence improves in care delivery and
Staff can demonstrate their Care in the best possible way by
preventing pressure damage.

**Are We Well Led** – The leadership of the home demonstrates
investment in the staff to improve the standards of care being delivered.
What other Impact is there?

◦ Staff knowledge improves
◦ Recognition of the work in the home and across the area through awards.
◦ There can be positive financial implications for the Home, improved grading from Local Authority and CCG audits
◦ Resident Care is second to none and individuals with inherited sores are healing when it wasn’t thought possible.
◦ Reputation of the service improves and remains positive from MDT Professionals
How has the home rolled it out
How has the home rolled it out

The TVN support Team first introduced the React to Red DVD in March 2015 to Clumber Court

There is a fantastic support offered by the TVN Team which is pivotal in the success of the programme, their link meetings reinforced the React to Red with the link Champions at every meeting.

Tessa Anders and Simone Ritchie our TVN support team delivered our initial training to a range of staff interested in Tissue Viability, those staff then had the responsibility of sharing that information across the teams.

We set about ensuring that all immediate care staff were the first to watch and understand the principles of react to red.

We included it as part of the induction programme

We set up information training boards and reference files for staff

Simone monitors our training numbers each month so it never gets forgotten and the link meetings discuss ways forward to ignite the interest to stop the pressure.
What’s next?

The Head of Nursing for Maria Mallaband, Clinton Taylor, has developed a work book for React to Red for staff to complete and to maintain their knowledge and focus.

The knowledge and skills from the work book will continue to reinforce the DVD training.

As a team we are aiming for 0% acquired pressure sores
Understanding the impact of the training
Understanding the impact of the training

We have won an award for 0% acquired pressure sores – a fantastic achievement by the team

The team know that they do everything that they possibly can to eliminate the risk to a person developing a pressure sore, because they have the knowledge to know what is needed to keep that person safe.

There will be unavoidable sores and as regrettable as they are the impact is less because everyone knows, everything possible has been put in place to try and prevent that situation happening.

The Tissue Viability Team can be confident that the staff at the Home are following the principles of React to Red which gives confidence in the services a Home Manager is running.

The reputation of the service is enhanced

But the singular most important impact is: **Residents are less likely to develop pressure related damage.**
Pressure Ulcer Risk Assessment – PURPOSE T

Dr Susanne Coleman
Identifying those at risk of PU development

- In UK secondary care hospitals approx 0.34% of hospital admissions develop a new PU
  - ie majority of patients not at risk (short stay/elective)

- Clinical challenge is to identify those at risk so preventative interventions can be implemented

- Structured approach to risk assessment is advocated – in clinical practice PU Risk Assessment Instruments (RAIs) and clinical judgement are routinely used
PU Risk Assessment Scales/Tools

Benefits:
- Raises awareness of risk factors
- Minimum standard of risks assessed
- Improved documentation
- Crude indicator of risk
- Framework for care

Limitations:
- Variable development methods
- Lack of agreement of which risk factor should be included
- Limited usability testing with clinical nurses
- Lack of patient/carer involvement in the acceptability of assessment methods
- Variable validity and reliability
- Do not distinguish between those with pressure ulcers and those without
- Full assessment undertaken on all patients even those obviously not at risk
- Numerical score often used as a basis for interventions
PURPOSE Programme of Research
Robust Development Methods for a new RAI – PURPOSE T

Identify risk factors (RF) predictive of PU development?

Which RFs are important for summarising patient risk?

Cause and effect/relationships

How can we assess risk in clinical practice?

Is it effective & what else do we need to do reduce PUs?

Systematic Review of PU epidemiological evidence.

15 RF domains & 46 sub-domains. KEY RF: Immobility, Skin/PU Status, Perfusion.

Consensus Study: Expert Group, PURSUN, Evidence.

Immobility, Skin/PU Status (existing/previous), Perfusion, Diabetes, Sensory perception, Moisture, Nutrition.

Development of PU conceptual framework and Theoretical Causal Pathway
Theoretical schema of proposed causal pathway for PU development

Other Potential Indirect Causal Factors
- Older age
- Medication
- Pitting oedema
- Chronic wound
- Infection
- Acute illness
- Raised body temperature

Key Indirect Causal Factors
- Poor Sensory perception & response
- Diabetes
- Moisture
- Poor nutrition
- Low Albumin

Direct Causal Factors
- Immobility
- Skin / PU Status
- Poor perfusion

Outcome
- Pressure Ulcer

Coleman et al 2014 b JAN
PURPOSE Programme of Research
Robust Development Methods for a new RAI – PURPOSE T

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Immobility, Skin/PU Status (existing/previous), Perfusion, Diabetes, Sensory perception, Moisture, Nutrition.

Development of PU conceptual framework and theoretical causal pathway

Design, Pre-testing & Clinical Evaluation of PURPOSE T with clinical nurses.

Pre-test: improved usa/acceptability, content validity confirmed.

Clinical Evaluation: Vgood inter & test-re-test reliability for assessment decision; Moderate to high associations for Convergent Validity.

PURPOSE T Implementation, Predictive validity, care processes and clinical effectiveness. Active skin monitoring

Future Research
PURPOSE T

Step 1 - screening

Mobility status - tick all applicable
- Walks independently with or without walking aids
- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods

Skin status - tick all applicable
- Normal skin
- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin e.g. bland/bleach redness that persists, dryness, paper thin, moist

If ANY yellow boxes are ticked, go to Step 2
If ONLY blue box is ticked

No pressure ulcer not currently at risk
Tick if applicable
Not currently at risk pathway

Step 2 - full assessment

Analysis of independent movement
Tick the applicable box (where frequency and extent categories meet)
- Extent of independent movement
  - Raket of all pressure areas
  - Doesn’t move
  - N/A
  - N/A
- Major position changes
  - N/A

Sensory perception and response
- tick as applicable
- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure

Moisture due to perspiration, urine, faeces or exudate - tick as applicable
- No problem/Occasional
- Frequent (2-4 times a day)
- Constant

Diabetes - tick as applicable
- Not diabetic
- Diabetic

Perfusion - tick all applicable
- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular/arterial disease

Nutrition - tick all applicable
- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Current Detailed Skin Assessment - for each skin site tick applicable column for either normal skin, vulnerable skin or record PU category if applicable, tick if pain, soreness or discomfort present at any skin site as applicable

Nutrition - tick all applicable

Previous PU history - tick as applicable
- No known PU history
- PU history - complete below
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category)

Approach Site PU cat Scar No scar

Other relevant information (if required)

Step 3 - assessment decision

If ANY pink boxes are ticked/complete, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

If ANY orange boxes are ticked (but no pink boxes), the patient is at risk.

If only yellow and blue boxes are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

PU Category 1 or above or scarring from previous pressure ulcers
Tick if applicable
Secondary prevention and treatment pathway

No pressure ulcer but at risk
Primary prevention pathway

No pressure ulcer not currently at risk
Tick if applicable
Not currently at risk pathway
Need for Active Skin Monitoring in Practice

- Recognise
- Respond
- Redness
- Symptoms
- Escalate

Need for more objective measure for assessing PU Risk
Implementation of PURPOSE T

Supported by suite of documents, registration
http://medhealth.leeds.ac.uk/accesspurposet:

- PURPOSE T
- PURPOSE T User Manual
- PURPOSE T Translation Guidance (on request)
- Sample/draft care plans
- Material to Assist training: PowerPoint presentation & Case Studies

PURPOSE T implemented in:

- 2 large acute NHS Trusts
- 3 Community NHS Trusts,
- 1 Hospice
- 1 Nursing home
- Over 70 others interested in implementation registered to use
Acknowledgements

- PhD Supervisors: Prof Jane Nixon & Prof Andrea Nelson
- Expert Group
- PURSUN
- Clinical Nurses involved in pre-testing & clinical evaluation
- PURPOSE Risk Assessment Project Team

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PURPOSE T: The RDaSH Story

Dawne Squires
CNS in Tissue Viability
Background;

• Suite of tissue Viability Policies for review
• Audit results
• Awareness of PURPOSE T and attendance at February conference
Rationale for choice

• Screening stage for all patients
• Follow-up full assessment for patients with potential or actual risk identified
• Care plan pathway to support decision making
Preparation of tool

- TPP system One Template
- Paper format

## Pressure Ulcer Risk Assessment - PURPOSE T

<table>
<thead>
<tr>
<th>Patient name</th>
<th>ODE</th>
<th>Hospital/NHS number</th>
<th>Ward</th>
</tr>
</thead>
</table>

### Step 1 - screening

**Mobility status** - risk of applicable  
Works independently with or without walking aid  
Needs the help of another person to walk  
Sits or lies at the majority of time in bed or chair  
Remains in the same position for long periods

**Skin status** - risk of applicable  
Current PU category 1 or above  
Vulnerable skin e.g. Eczema, back, heel, friction, immersion, pressure, burns, eczema, dry, other, at risk

**No pressure ulcer not currently at risk**  
**Not currently at risk**

### Step 2 - full assessment

#### Analysis of independent movement

- **Task** (the applicable low section is greyed out)
- **Position** (the applicable low section is greyed out)
- **Diet** (the applicable low section is greyed out)
- **Frequency** (the applicable low section is greyed out)

#### Sensory perception and response

- **Sensory perception** (the applicable low section is greyed out)
- **Response** (the applicable low section is greyed out)

#### Nutrition

- **Nutrition** (the applicable low section is greyed out)

#### Perfusion

- **Perfusion** (the applicable low section is greyed out)

#### Current Detailed Skin Assessment

- **Skin condition** (the applicable low section is greyed out)
- **Pre-exist PU score** (the applicable low section is greyed out)
- **Other skin (s) relevant** (the applicable low section is greyed out)

#### Step 3 - assessment decision

**PU Category 1 or above**

**Secondary prevention and treatment pathway**

**No pressure ulcer but at risk**

**No pressure ulcer not currently at risk**

---

**Notes**

PURPOSE T Version 1.1 - Copyright © Clinical Trials Research Unit, University of Leeds and Leeds Teaching Hospitals NHS Trust, 2013 (Do not use without permission)
Preparation of tool

Skin Inspection: Take your BEST SHOT

- Buttocks (ischial tuberosities)
- Elbows / ears
- Sacrum (bottom)
- Trochanters (hips)
- Spine / shoulders
- Heels
- Occipital area (back of head)
- Toes
The process
The care pathways

- Green Pressure Ulcer Risk Assessment Status – Not currently at risk pathway (DP7965)
- Amber Pressure Ulcer Risk Assessment Status – Primary prevention pathway (DP7966)
- Red Pressure Ulcer Risk Assessment Status – Secondary prevention and treatment pathway (DP7967)
The procedure for re-assessment

- In patient / ward areas in line with care plan goals e.g. per shift, once per week
- Community – in line with complexity score;
  Level 1 – 52 weeks
  Level 2 – 26 weeks
  Level 3 – 12 weeks
  Level 4 – (1 week) } every 4 weeks
  Level 5 – ( every visit) } every 4 weeks
The procedure for reassessment

• In line with complexity:
  MUST assessment
  Moving & Handling assessment
  Mental Capacity

• At every community nurse visit:
  skin inspection
  turns & reposition (evidence/advice)
  pressure relief equipment allocation & check
The procedure for reassessment

• If patients condition changes undertake PURPOSE T risk assessment
• If patient reports any soreness or problems with skin undertake and complete skin assessment
• If carers or family member report any changes in skin integrity
Implementation

- Introduced with the release of the updated policies
- Matron and senior meetings
- Roadshow with the tools
- Inclusion into the monthly educational sessions for new starters and update sessions
• Thank you for listening ......
• Exciting 3 month pilot project being sponsored by NHS England
• Building upon work from Bassetlaw Clinical Commissioning Group
• Test case the React to Red in an Acute setting
• Using DBHfT methodology for Pressure ulcer education
• Monitor incidence of pressure ulcers/IAD within identified clinical areas
• Measure effect of the training on nominated staff
Project Time Line

• Project start date - 4\(^{th}\) January 2016
• Runs for until end of March 2016
• Project Nurse working 34 hours per week
• Funding from NHS England
MSK Care Group

- Pilot within Musculoskeletal & Frailty Care Group with full support from Head of Nursing, Matrons and Ward Managers

- Focus on 3 wards
- B5 - Orthopaedic
- A4 – Stroke Unit
- St Leger - Orthopaedic

- 8 Healthcare Assistants nominated from each ward
- Names provided by Ward Managers
Utilise the REACT to RED Concept

• Translate its success into an Acute setting
• Excited to have a new programme for Health Care Assistants
• Mirror the Trust’s PU Educational strategy for Trained Nurses
• 2 Classroom sessions
• Practical application of knowledge via ward based clinical sessions with Project Nurse
• Each staff member to demonstrate competence in 6 skin assessments
Apply the REACT to RED Concept
Development of 7 components
Classroom and Practical Application

Introduction
Skin Inspection
Pressure Ulcer Risk Factors and Care Planning
Preventative skin care
Turn and Repositioning
Equipment
Nutrition and Hydration
Pressure ulcer categorisation, Safeguarding and Reporting

Success criteria identified for each component
The Impact of Pressure Ulcers

Establish the impact of R2R Acute upon our patients, staff and the organisation.
The Patient Impact

• Monitor the Incidence of Pressure Ulcers
• Monitor the Incidence of IAD/MASD
• Collect baseline data for each of the 3 wards from the Trust’s Electronic dashboard
• TVN to see all patients during the 3 month project to verify accuracy of reporting
The Staff Impact

• Staff to determine their level of knowledge pre training programme using a self assessment scoring system

• 5 = Excellent
• 4 = Very Good
• 3 = Good
• 2 = Average
• 1 = Poor
The Staff impact

- Written assessment prior to the classroom session to quantify the staff members actual level of knowledge

  - 100% = 5 = Excellent
  - 90 – 99% = 4 = Very Good
  - 75 = 89% = 3 = Good
  - 50 – 74% = 2 = Average
  - Less than 50% = 1 = Poor

- Individual results fed back at the start of the classroom session
- Group knowledge for Group 1 = 48%
The Staff impact

• Two Classroom sessions held
• Excellent evaluations
• Written assessments repeated at the end of the day to determine progress made
• Group knowledge for Group 1 = 85%
• Work to commence on the practical application of knowledge and competency of skin assessments
The Impact on the Organisation

- Reduction in Pressure Ulceration
- Reduction in IAD/MAISD
- Increased levels of knowledge for staff members
- Development of skillset for Project Nurse
- Achievement of Quality Targets i.e. CQUIN
Thank You for Listening
Moisture lesions

Brenda M King
Nurse Consultant Tissue Viability
Sheffield Teaching Hospitals
What are the risks

• Failure to adequately recognise moisture damaged skin and provide appropriate treatment will lead to an increased risk of further skin break down

• Moisture lesions are preventable and do cause significant pain and suffering
Moisture lesions

• Can be caused by any form of moisture
• Urine and feaces
• Sweat
• Wound exudate
• Saliva
Moisture lesions

- Often misclassified as pressure ulcers. Moisture lesions are skin lesions not caused by pressure and or shear.
- **Pressure ulcers** – pressure and or shear must be present.
- **Moisture lesion** – moisture must be present eg shiny wet skin.
- May be combined lesions.
Often coexist with pressure
But is wound exudate or urine the problem?
Incontinence Associated Dermatitis

• Spreading the word to reduce the risk of IAD is as important as considering the ‘React to Red’
• Recognition for front line carers of redness due to pressure and redness due to IAD
• Recognising the problem to reduce the risk of skin breakdown
Incontinence Associated Dermatitis

• Consider using grading tools to support the front line carer

0 = Healthy skin
1 = Mild excoriation
2 = Moderate excoriation
3 = Severe excoriation

NATVNS (Scotland)
What does the terminology mean to the carer

- Incontinence Associated Dermatitis
- Perineal dermatitis
- Diaper dermatitis
- Excoriation
- Moisture lesions
- Same problem as persistent non blanching erythema – ‘React to Red’
- Nappy rash!!!!
Does moisture damaged skin break down with the help of mechanical forces?
How much shear is needed?
Risks of moving and handling
Moisture + friction + shear?
Pressure V Moisture

- Location
- Depth
- Edges
- Colour
- Tissue type
  - Necrosis, slough
- Shape
  - Circular or irregular
  - Diffuse areas
  - Kissing ulcer
Nicorandil induced perianal ulceration
Conclusions

We should not underestimate the risks of not preventing moisture damage to skin as this should be an important aspect of any pressure ulcer prevention programme.

It is essential that front line carers have the knowledge and skills to identify risk, effectively apply preventative measures and recognise early signs of skin problems associated with IAD to promote proactive management.
Device related Pressure Ulcers – Working together

Task and Finish Group
Pressure ulcers occur in patients when the skin covering areas break down due to pressure on that area causing an ulcer to develop:

- Pain and discomfort for our patients.
- Anxiety for families.
- Increased length of stay.
- Infections.
- Ongoing care in the community.
Progress to date

Improvement priority for the Trust

Hospital acquired pressure ulcers from 2013/14 and 2014/15

- Grade 2 - Hospital Acquired
- Grade 3 - Hospital Acquired
LEARNING FROM PRESSURE ULCERS INVESTIGATION

Each harm event has prompted a full Root Cause Analysis and review by a panel within the Trust. There has been some learning and improvement required in each of these cases which is detailed below:

- Analysis of Grade 2 and 3 acquired pressure ulcers reveals the following trends:
  - Acuity of illness
  - Poor nutritional status – MUST scores not always completed
  - Poor peripheral vascular supply to skin (peripheral vascular disease / inotropic drugs)
  - Decrease in mobility
  - Related to devices – Plaster, Thomas splints
‘Focus on’ device related pressure ulcers

Task and Finish Group

- Associate Director of Nursing – Chair.
- Matrons Scheduled Care.
- Trauma Nurse.
- Therapies Manager.
- Plaster room Manager.
- Tissue Viability Team.
- Corporate Nursing team.
‘Focus on’ device related pressure ulcers

The approach

- We reviewed all of the recent device related incidents (RCA) and associated actions taken and recommendations made.
- We reviewed the current evidence, including: device related pressure ulcers, best practice statements and the competency framework for orthopaedic and trauma practitioners.
- The group also considered the RCN guidance on traction and the principles of application.
- Plaster application techniques, padding options.
- Undertook some ‘pressure testing’ experiments.
Introduction Orthopaedic Devices Care – competency training

- Single Point lesson to support staff training.
- Introduction of a care pathway for Thomas Splint management.
- Introduction of training and competency for POP application.
- Review of the care and comfort round documentation.
- Option of a daily review by the trauma nurse, plaster room staff, matron of any patient with a cast or a device on an outlying ward.
Actions - High Risk Patients

Introduction of key initiatives to support high risk patients

- Introduction of the red sticker to alert staff.
- Plaster room staff.
- Ward and department staff.
- Electronic version being explored
- Felt we needed more........
Introduction of the Red band on the cast.

- Visual alert.
- Advice for plaster room staff on high risk patients.
- Patient and staff awareness.
- Communication to the wider team.
Focus On...

Device-Related Pressure Ulcers - Plaster casts

A 2009 safety alert notified healthcare staff of the impact of delayed recognition of pressure ulcers under plaster casts and the resulting harm (including amputation). The key learning from the alert is the early identification of patients at risk. Good casting techniques and monitoring should prevent complications such as pressure ulcers in most cases. Warrington and Halton hospitals have seen and number of pressure ulcers related to Plaster casts and have introduced the red stripe on the cast.

Action - Red Banded Cast

The red band placed around the plaster cast aims to act as a reminder that the patient is at risk of developing a pressure ulcer. Extra consideration should be taken in the care of these patients appropriately. The following steps should be taken:

- Patient’s position changed frequently
- Patient encouraged to mobilise if possible
- The heel should be relieved of any pressure
- Care documented on the care and comfort round

Alert Sticker

This sticker is placed on the patient notes and indicates a patient at high risk. This will become an electronic alert in Lorenzo.

Care - Plaster Room Support

Plaster Room Direct Number: 01925 662442

Any patient in hospital with a cast should be reviewed by the Trauma Nurse. Bleep Emma Hallam 113

Patients who are high risk in the community are usually seen very frequently in the Fracture Clinic or Plaster Room. Please ring for advice if this is not the case.
Patient Experience

Patient story
So what's changed

1. No Further hospital acquired pressure ulcers, associated with a POP
2. Community acquired related to POP (x2)
Next Steps

1. Operational group continuing to meet.
2. Cascade to all wards in the Trust – Unscheduled Care.
3. Cascade to our community colleagues, with a view to roll out the red cast to the community.
4. Communication and share the work...local paper, patient story?
Thank you - Any questions?