

Skin matters

Information for service users



RDaSH

nurturing the
power in our
communities

Patient information

Name of patient:.....

Date of birth:

NHS number:.....

Healthcare provider or district nursing team (include contact details i.e. SPA number):
.....

Further to our assessment we have found that there is:

- A risk of developing a pressure ulcer
- A pressure ulcer which is close to the skin's surface (location):
- A pressure ulcer which extends into the deeper tissues (state location):
.....

We recommend that you follow the advice within this leaflet as well as the advice provided by your healthcare provider or district nursing team.

If anything changes, or you require further advice and support, please refer to your healthcare provider or district nurse.

Advice follows
pressure ulcer assessment
tool (ASSKING)
(NHS Improvement, 2018)

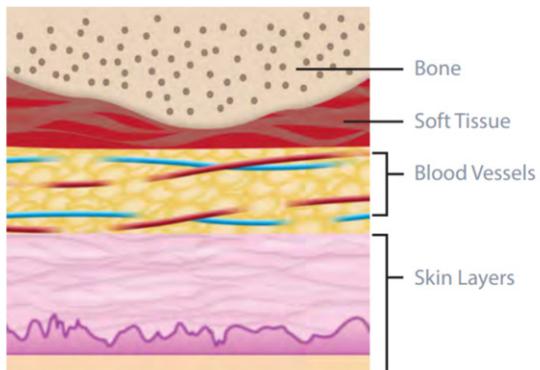
A – Assess Risk
S – Skin assessment
S - Surface
K – Keep moving
I – Incontinence
N - Nutrition
G – Giving information

What is a pressure ulcer?

A pressure ulcer is a localised injury to the skin and/or underlying tissue, usually over a bony area, as a result of pressure or pressure in combination with shear (EPUAP, 2014) www.epuap.org.

Pressure ulcers are most likely to develop over bony areas like your bottom or spine, but can also occur if something is pressing against the skin such as a splint, oxygen mask, end of the bed or poorly fitting footwear.

Normal

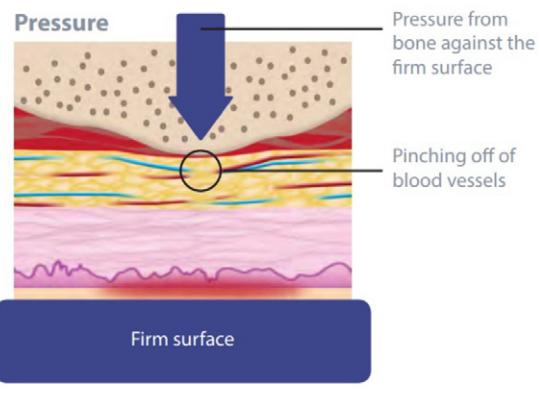


How does a pressure ulcer occur?

Pressure ulcers occur on areas of the skin that are under direct pressure and can happen if you have problems moving, this means the weight of your body is always putting pressure on the same areas of skin. Bony areas are commonly affected such as elbows, heels, hips and spine.

The pressure can come from lying in bed, sitting in a chair or a wheelchair for a long period of time. This can lead to the blood supply being disrupted to the skin tissue and the area being deprived of oxygen and nutrients, leading to skin damage.

Pressure ulcers can happen over a short period of time if a large amount of pressure is applied, they can also happen with less pressure but over a longer period.



The first sign of tissue damage may be pain, the area may feel warm, cool, numb, swollen, hard or boggy. Skin may be red on light skin tones but it can be purple or blue on dark skin tones.

Friction and shearing add additional complications to pressure.

For example, slipping down the chair or bed or an involuntary muscle spasm.

Shear

When tissues are stretched in different directions, the skin stays static, and the tissues underneath are pulled in opposite directions causing internal tissue damage.

Example

When a person slides down the bed or chair.

Friction

When two surfaces rub together the top layer of skin gets stripped away, contributing to tissue damage.

Example

When a person's heels rub on a surface, such as a mattress, footstool or ill-fitting footwear.

Who is at risk?

Anyone can be at risk of developing a pressure ulcer.

What increases the risk?

- Trouble moving and not changing position
- Not feeling pain or having reduced sensation over part or all of the body
- Incontinence
- Change or deterioration in health or recent surgery
- Poor diet and not drinking enough water
- If you are very young or very old or considered clinically vulnerable

- Older people who are ill or have suffered an injury like a broken hip
- People who have physical disabilities that may affect their posture, spinal cord injuries or neurological conditions
- People who have had a pressure ulcer before
- Poor or reduced circulation
- Lifestyle choices like smoking and drinking alcohol.

What must you do?

What to look and feel for:

- Red or dark patches that do not disappear within 1 to 2 hours
- Pain or soreness
- Warmer or cooler areas
- “Boggy” feeling or hardened area
- Broken skin/ulcer

These are all early warning signs that pressure, shear or friction is happening. Usually, the skin will recover by removing the cause, this is the most effective way to prevent skin damage.

If you find an area of redness or discolouration that does not blanch (see next page) please report this to your healthcare provider or district nurse.

The skin tolerance test also known as the blanch test

There is a simple test you can do to see if there is skin damage and a possible pressure ulcer developing.



Normal skin response to pressure, like your elbow when you lean on it.



Press finger over reddened area for five seconds, then lift finger.



If the area blanches, goes light, it is not a pressure ulcer. If it stays red, it is the start of pressure damage and the beginning of an ulcer.

Note:

Darkly pigmented skin does not always blanch. Signs to look for in early tissue damage include:

- Change in skin colour, this may present as redness, darkening, lightening or grey, blue and purple tones
- Skin may feel tight, spongy or appear shiny
- Skin may be warm or cold
- Numbness, swelling, hardness or pain may be present.

(Wounds UK, 2021)

Examples:



Surface

Pressure relieving equipment will help relieve pressure.

The following pressure relieving/redistributing equipment is recommended/provided:

Delete as appropriate Medequip: 01302 203853 REDCROSS: 03451272911

- Mattress
- Cushion
- Other

Please consider the following in relation to the equipment provided.

- Please take any removable equipment such as cushion or heel protectors on all journeys
- Please ensure equipment is cleaned down with soapy water and dried thoroughly if it becomes contaminated
- Check for tears, splits and faults regularly
- Please make sure that the mattress is always plugged in and set in accordance with manufacturers guidance.

What else can you do?

- Ensure that footwear is well fitting and not marking the feet or toes
- Ensure that any medical devices, glasses and hearing aids are not causing redness
- If using a specialist wheelchair or wheelchair cushion, please refer to your supplier with any concerns.

If you think that any pressure relieving equipment is damaged or faulty please contact your equipment provider straight away or contact your healthcare provider or district nurse.

If you have tried the equipment and feel it is not suitable, please discuss with your healthcare provider as an alternative may be available.

Please note it is against RDASH policy for a smoker, or patients that live with a smoker, to be provided with an air mattress due to a fire risk. An alternative will be provided.

Skin assessment

Full skin check is advised to allow for early detection of any pressure damage.

Please check all areas and vulnerable areas every.....

A mirror may be useful to see out of reach areas.

We have found pressure damage/vulnerable pressure areas to the following areas:

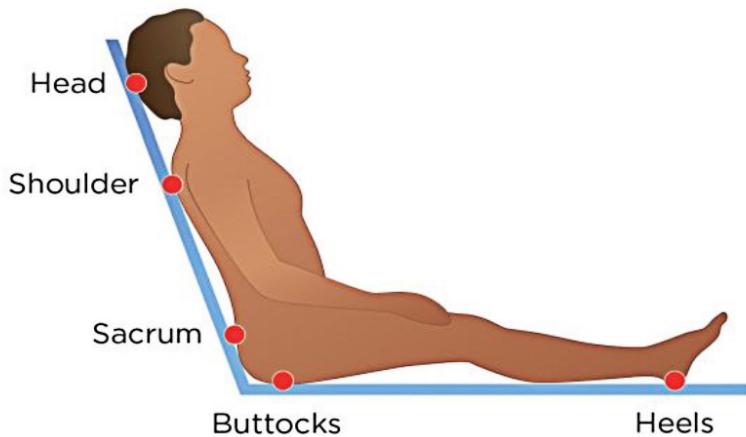
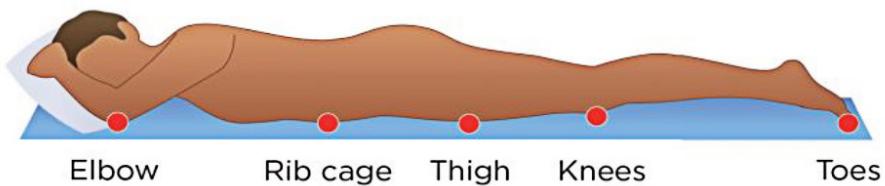
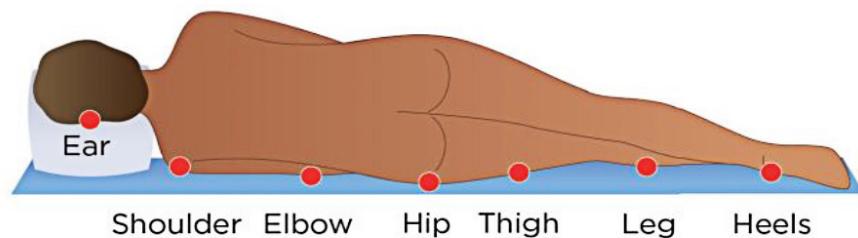
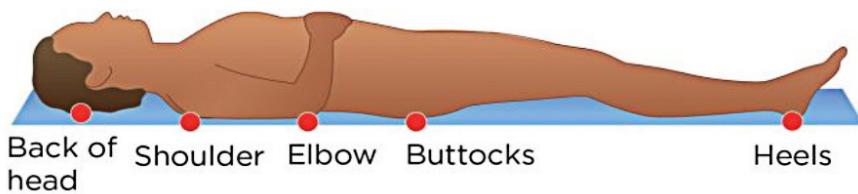
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If any red areas are found, please complete the blanch test. If none blanching please contact healthcare provider/district nurse.

If unable to assess due to skin tone but other signs present, contact your healthcare provider or district nurse as soon as possible.

Fig 1. **Areas at greatest risk of pressure damage**



Keep moving

One of the best ways to prevent a pressure ulcer is to regularly change position and keep moving as this allows for the blood supply to return and recover.

This can be as simple as standing and walking on the spot for a few minutes every hour or transferring into a different position. It is important to **avoid** putting pressure on vulnerable or existing skin damage.

Regime recommended:

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Please reposition fully at least every.....hours during the day and at least every.....hours at night.

Avoid repositioning over existing pressure damage or redness.

Avoid sitting or lying in the same position for a prolonged amount of time try to move other areas of the body in between times for comfort when necessary.

Transfer aids:

.....

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Are recommended/provided to reduce friction and shear when repositioning.

Examples of repositioning:



Walking, movement or light activity.



Elevated or off loaded heels.



Transferring



30 degree tilt/resting

Incontinence/moisture

An excess of moisture will delay healing and increase the risk of skin breakdown.

Moisture damage can occur to the skin by prolonged contact of moisture to the skin's surface. This can be in the form of sweat, wound exudate, urine, faeces, or saliva.

Excessive moisture can result in moisture damage developing. Skin will become inflamed, it will look red and sore and be spread over a large area or found in skin creases or folds.

- We have identified the risk of excess moisture due to sweat/incontinence/wound exudate
- We have identified moisture damage to
due to sweat/incontinence/wound exudate.
- We recommend that you use
which should be applied every

Always wash skin with skin PH friendly products, pat the skin dry, avoid rubbing and ensure the skin is properly dried to avoid further moisture damage.

If you are a smoker, including e-cigarettes (or similar), ensure emollients being used are discussed with your healthcare professional and that these are low or paraffin free.

If you identify or experience a change in moisture or continence management, please contact your healthcare provider for further advice or signposting.

Nutrition

A healthy balanced diet can help in maintaining an ideal weight, reducing the risk of skin damage occurring, and promote wound healing. Anyone who is malnourished, underweight or overweight is at an increased risk of pressure damage.

Aim to maintain a regular meal pattern, ideally three main meals a day. If you are struggling with your appetite or feeling over faced, try a little and often approach to eating, with smaller meals and snacks throughout the day.

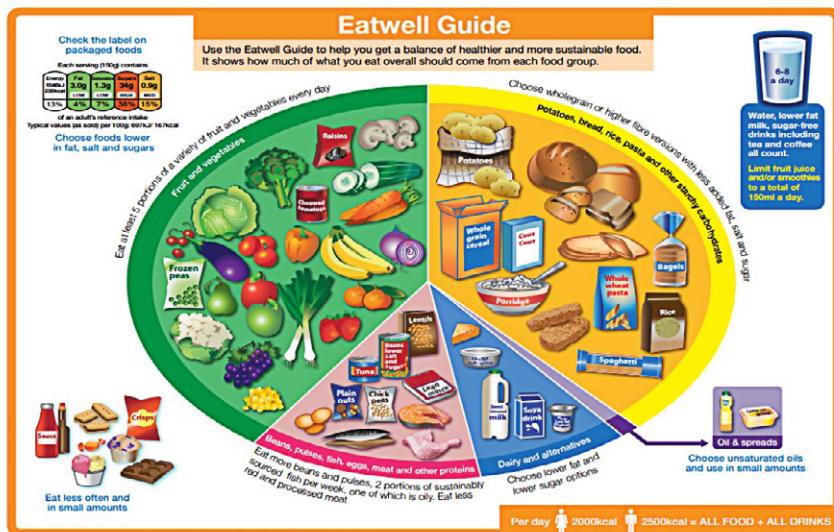
It is important to maintain a varied diet in the right amounts to provide the body with all the nutrients it requires, especially if wound healing is taking place.

Aim to include foods from all the groups in the Eatwell Guide, not forgetting at least 6 to 8 glasses or mugs of non-alcoholic drinks per day.

If you are struggling with your weight, then discuss a food first approach with your district nurse or healthcare provider.

- Food First Booklet has been given and discussed
- Dietary advice for pressure ulcers has been given and discussed if appropriate

If you require any further information, please discuss this with your healthcare provider.



Giving information

Educate others and promote self-care.

Any other relevant information? Please use this space to document any other information which may impact wound healing, such as long term conditions, smoking status and risks.

Past Medical History

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Any further relevant information

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Discussed with patient/nominated other:

Date:

Any concerns regarding this please contact your healthcare provider or district nurse team.

Skin matters

Preventing pressure ulcers, a guide for patients and carers.

We recommend that you follow the advice within this leaflet and provided by your healthcare provider. However, if anything changes or you require further advice or support, please refer to your healthcare provider or district nursing team.

Telephone no.

Name of Practitioner:

Signature:

Date:

Recipients Signature:

Print name:

Date:

For healthcare professional use only

- Photograph and upload into patient's clinical notes once completed and discussed.

