Launch of revised Policy for the Prevention & Management of Pressure Damage & PURPOSE-T

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Housekeeping

- **Add your name in the chat function** so your attendance can be taken and updated on your L&D portal.
- **Have your Camera on** to be FULLY PRESENT in the session.
- Add questions to the chat. Time at end to discuss.
- Please contribute when asked.
- **Please log yourself out at the end of the session.**

What we will cover:

- Why you're here.
- The skin & it's barrier function.
- What is a pressure ulcer & who is at risk of them?
- Categorisation of pressure ulcers.
- PURPOSE-T PU Risk Assessment Tool.
- aSSKINg Framework for assessment & management.
- When to escalate.
- What now.

Why are we bothered about pressure ulcers?

Patient experience

National Wound Care Strategy Programme

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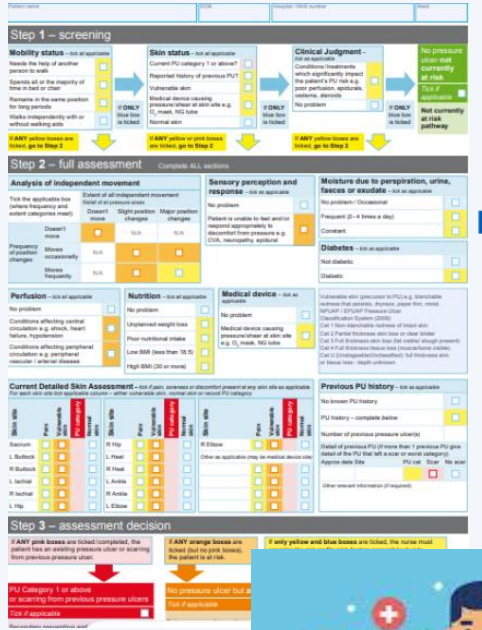
- Commissioned by NHS England
- Pressure Ulcers are in the ‘top ten harms’
- Evidence shows that unwarranted variation from evidence-based practice is a contributing factor
- Despite national & international clinical guidelines, there has been no up to date standardised pathway for implementing these guidelines in England

Key changes:

1. New pressure ulcer screening & risk assessment tool – **PURPOSE-T** will replace the Braden Tool
2. Everyone receiving care from a **health or care professional**
3. Use of the **aSSKINg care Bundle** to structure assessment and management



A ssessment of risk
S kin inspection and care
S upport surface selection and use
K eep your patient moving
I ncontinence and moisture care
N utrition and hydration management
G iving information

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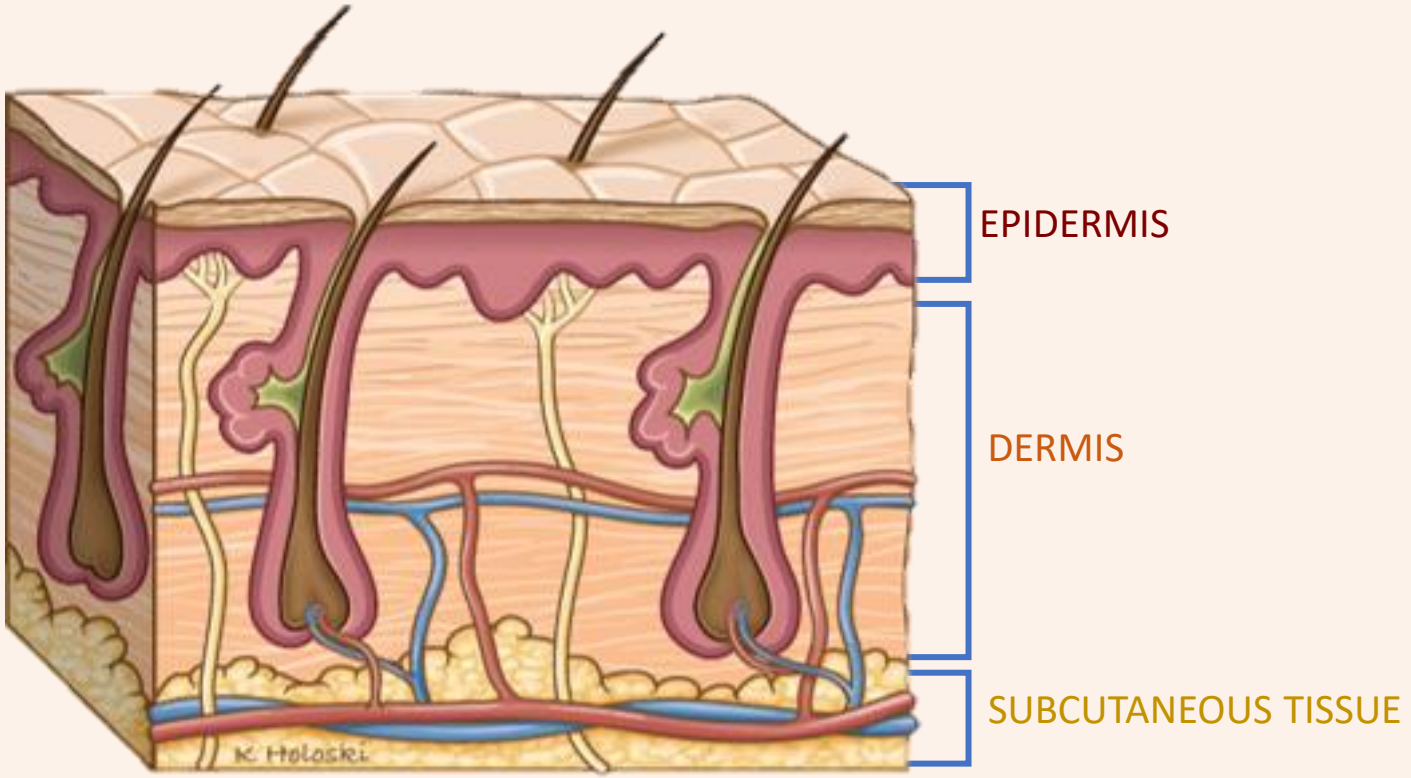
The Skin



Acts as a Barrier

Barrier Function of the Skin:

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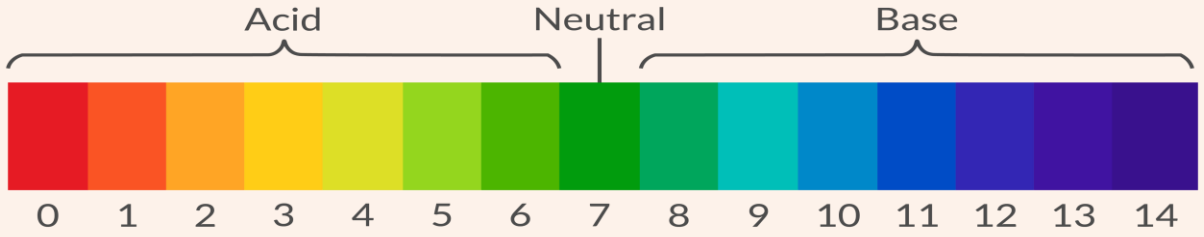
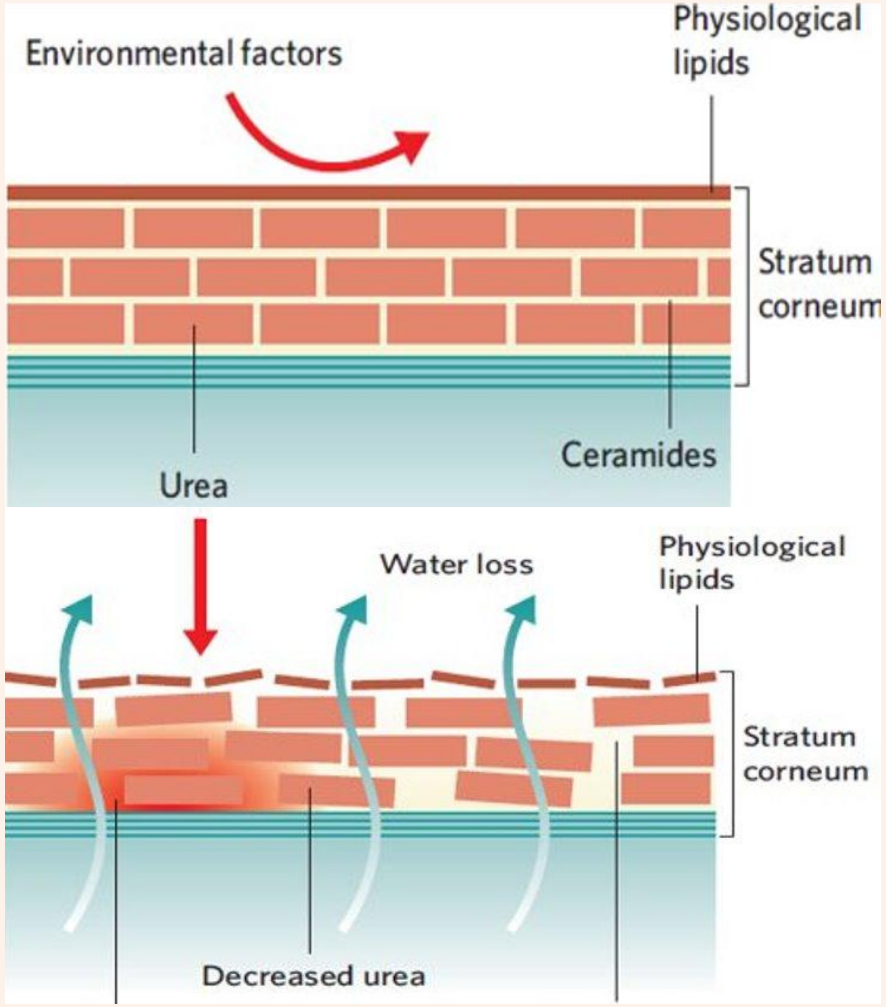
The **Epidermis** is made up of 5 layers with the outer most being the **Stratum Corneum** acting as our barrier. The Stratum Corneum is made up of 'bricks' or keratinocytes and 'mortar' or lipid matrix full of of ceramides.

Chemical Barrier – the acidic pH level in skin acts as the barrier against bacteria, the Acid Mantle.

Physical Barrier – the lipid matrix found in the stratum corneum, which prevents excessive water loss and avoid environmental factors permeating into the skin.





CHILDREN	ADULTS	OLDER ADULTS
Epidermis is 20-30% thinner than that of adults, making it more fragile.	Skin is thicker and more resilient	Epidermis thins and becomes more fragile, transparent and prone to tearing.
More sensitive and prone to irritation from external aggressors.	While still sensitive, it can tolerate stronger active ingredients	
Tends to lose moisture more quickly due to the thinner outermost layer & less oil/sebum.	Has a developed skin barrier that retains moisture more effectively.	Loss of oil and sweat gland function and natural moisturizing factors makes skin chronically dry & prone to itching.
Remarkable healing due to faster cell regeneration.		Slower healing rate due to aging process.

Impaired Barrier Function:

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Factors Impairing Skin Barrier Function:

- Age - infants: immature barrier; elderly: reduced lipid production,
- Genetic predisposition,
- Underlying skin disease e.g. eczema,
- Atopy or allergic tendency,
- Chronic inflammation or infection,
- Hormonal changes,
- Nutritional deficiencies (essential fatty acids, zinc, vitamins),
- Systemic illness (diabetes, renal or liver disease),
- Medications (topical steroids misuse, retinoids, chemotherapy),
- Behavioural factors (frequent washing, hot showers, scratching),
- Psychological stress.

Why are emollients important?

•Reduces trans-epithelial water loss,

•Low in pH like the skin,

•Reduces eczema, infection, skin tears and moisture lesions,

•Hypoallergenic.

Urea-containing emollients:

- Are important for older skin,
- Enables fluid absorption,
- Keeps cells well hydrated, reducing trans-epithelial water loss,
- Cells become more closely knitted together.
- Natural barrier function is repaired.

What is a Pressure Ulcer (Pressure Injury)?

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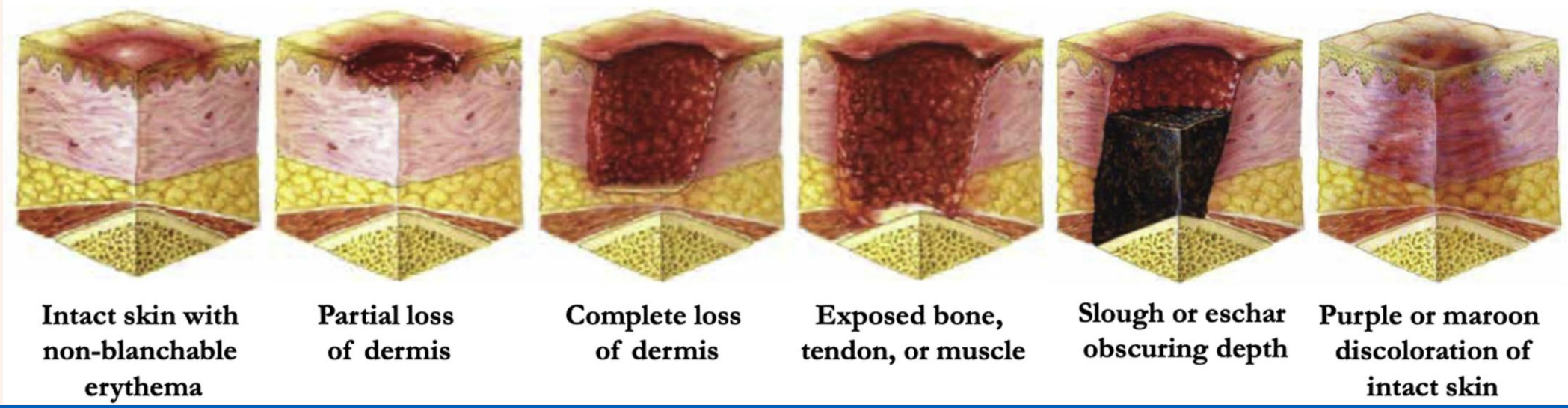
A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of 2 forces:

Pressure or **pressure in combination with shear**.

Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object (EPUAP (2019).



Pressure is a force acting perpendicular against the skin and soft tissues.

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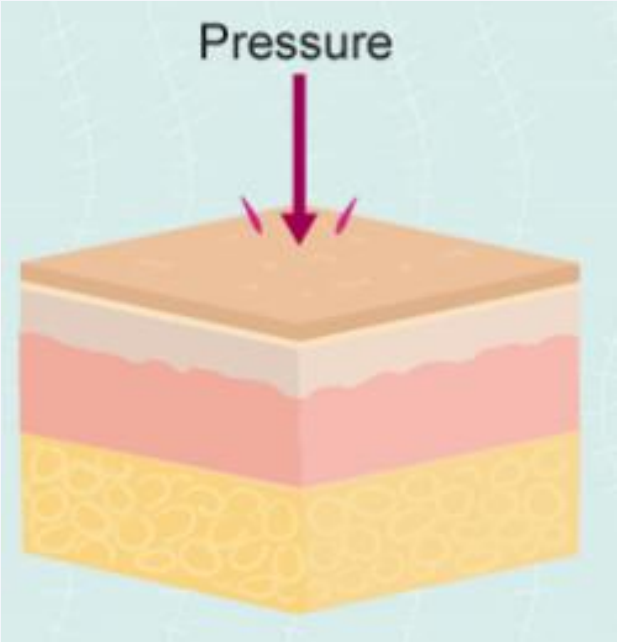

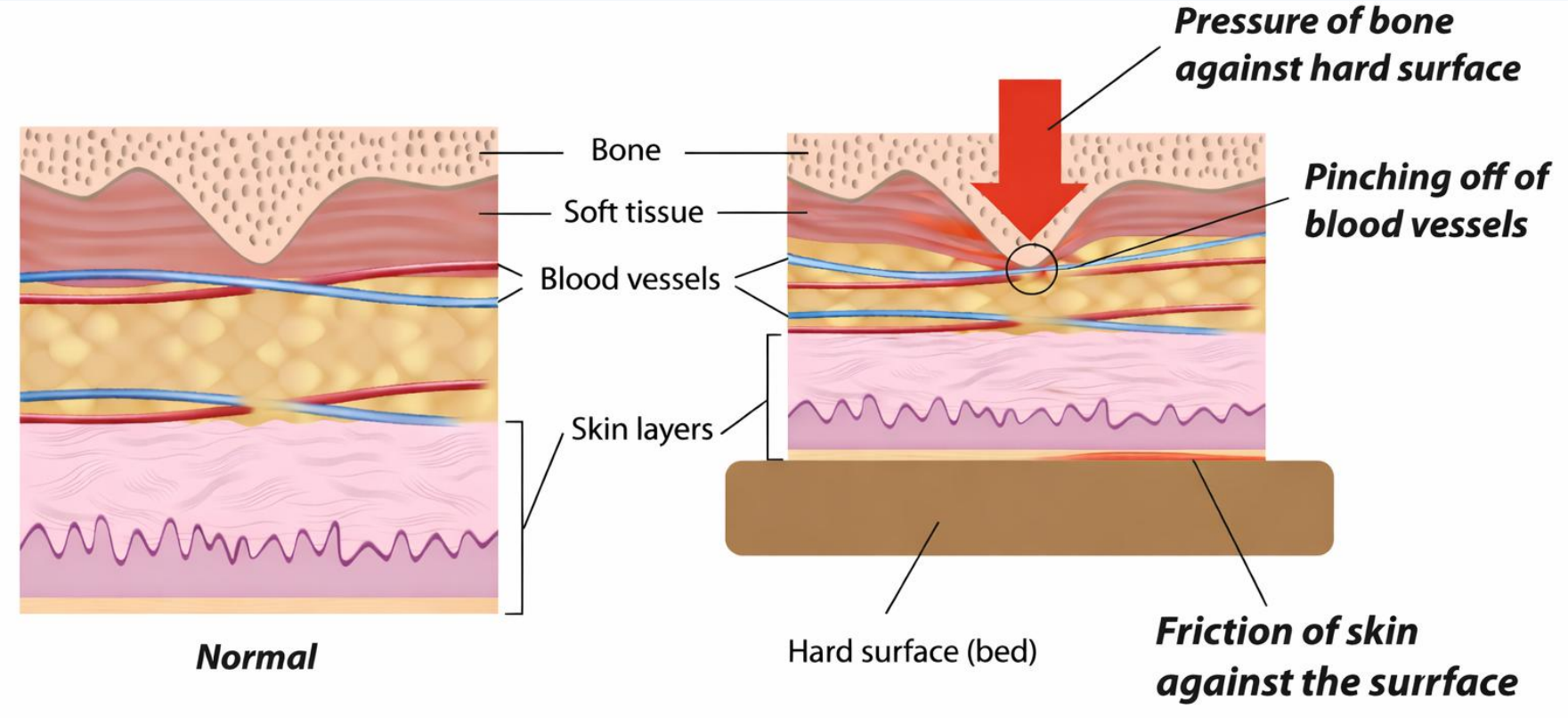

The harder the surface, the higher the pressures.

Shear is a force that acts parallel to the skin.

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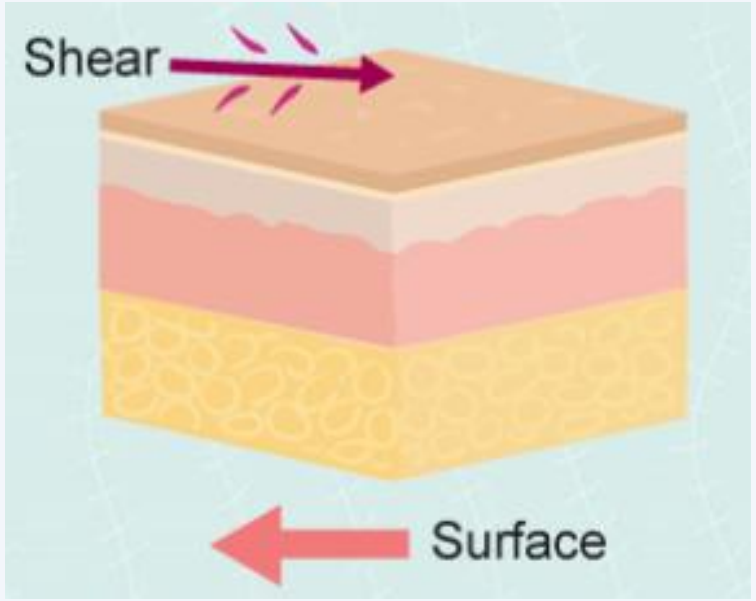

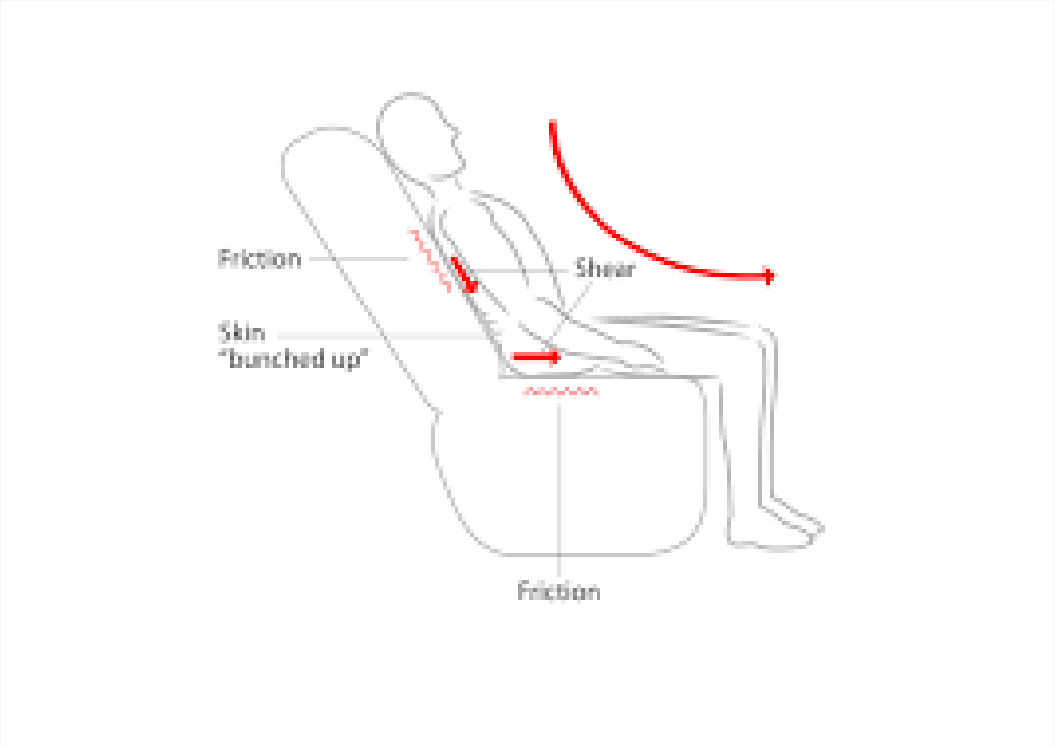

Friction – the rubbing of the skin over a surface.

What isn't a Pressure Ulcer/injury?

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- A skin tear
- A true bruise
- A foot ulcer NOT caused by pressure (podiatry)
- A wound on a leg not over a bony prominence or under a piece of equipment/surface
- A surgical wound that has broken down

None of the above wounds should be categorised.

Category 1 Pressure Ulcer:

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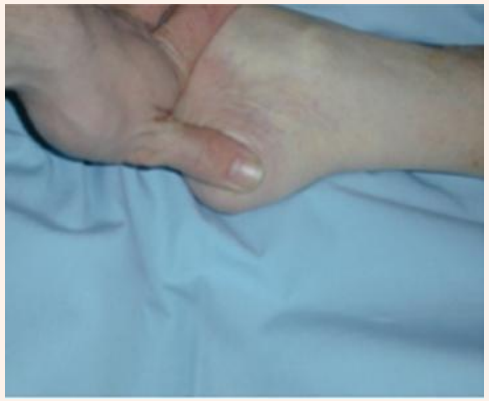
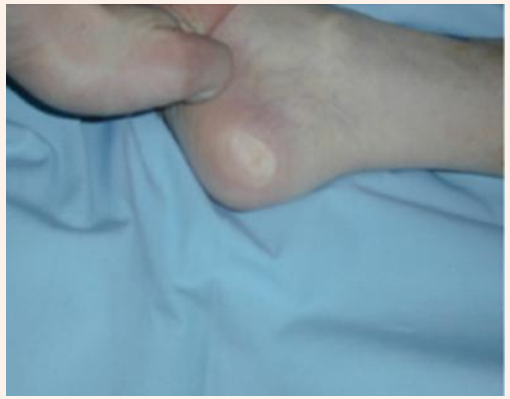
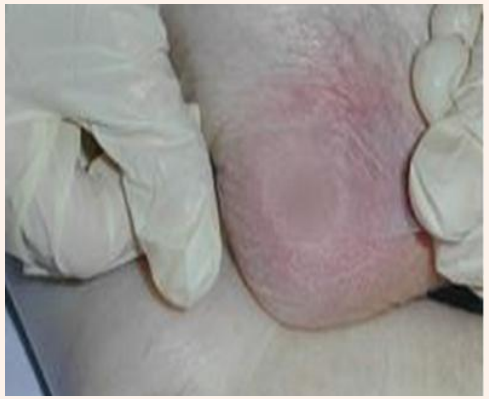
- Intact skin with localised, non-blanching erythema usually over a bony prominence.
- Indicates early tissue damage and risk of progression if pressure is not relieved.
- may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.







Blanching Test *– No colour change with pressure indicates collapse of small blood vessels = Category 1 Pressure Damage.*

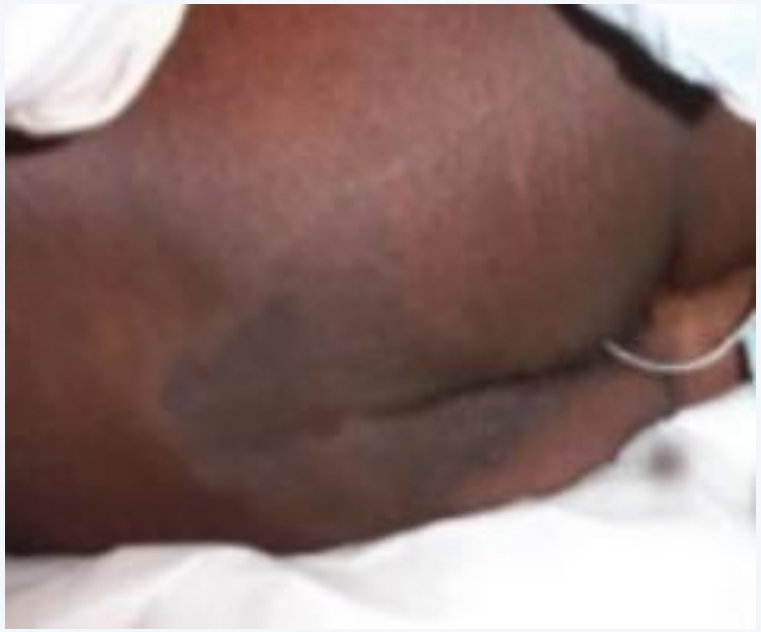
Why this stage matters:

First visible sign of pressure injury

Miss it → **rapid progression to skin breakdown**

Spot it early → **injury can be prevented**

Assessing different skin tones:



Questions to consider as part of the skin assessment:

- What is the colour like in comparison to the surrounding skin?
- Does the skin feel warm/cool? Are there any changes in temperature?
- Does the skin feel spongy of firm to touch?
- Does the skin look or feel shiny or tight?
- Is there any swelling or inflammation?
- Are there any changes in the texture of the skin and underlying tissue?
- Is there any pain, itchiness or change in sensation?

Wounds UK (2021) Best Practice Statement: Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones. Wounds UK, London. Available to download from: www.wounds-uk.com

Category 2 Pressure Ulcer:

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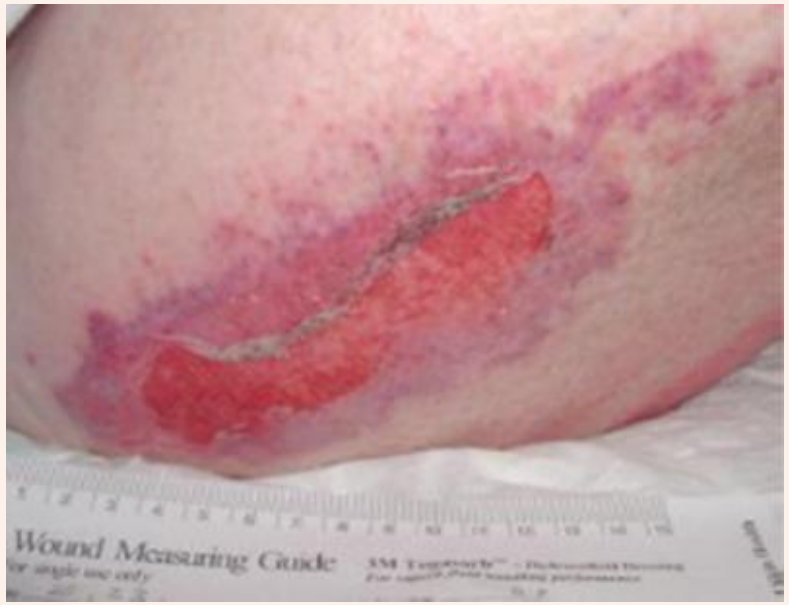
- Partial thickness skin loss – damage to the dermis and/or epidermis.
- A shiny or dry shallow open ulcer with a red pink wound bed, NO slough or bruising.
- Intact or open/ruptured serum-filled or serosanguinous filled blister.



This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

Category 3 Pressure Ulcer:

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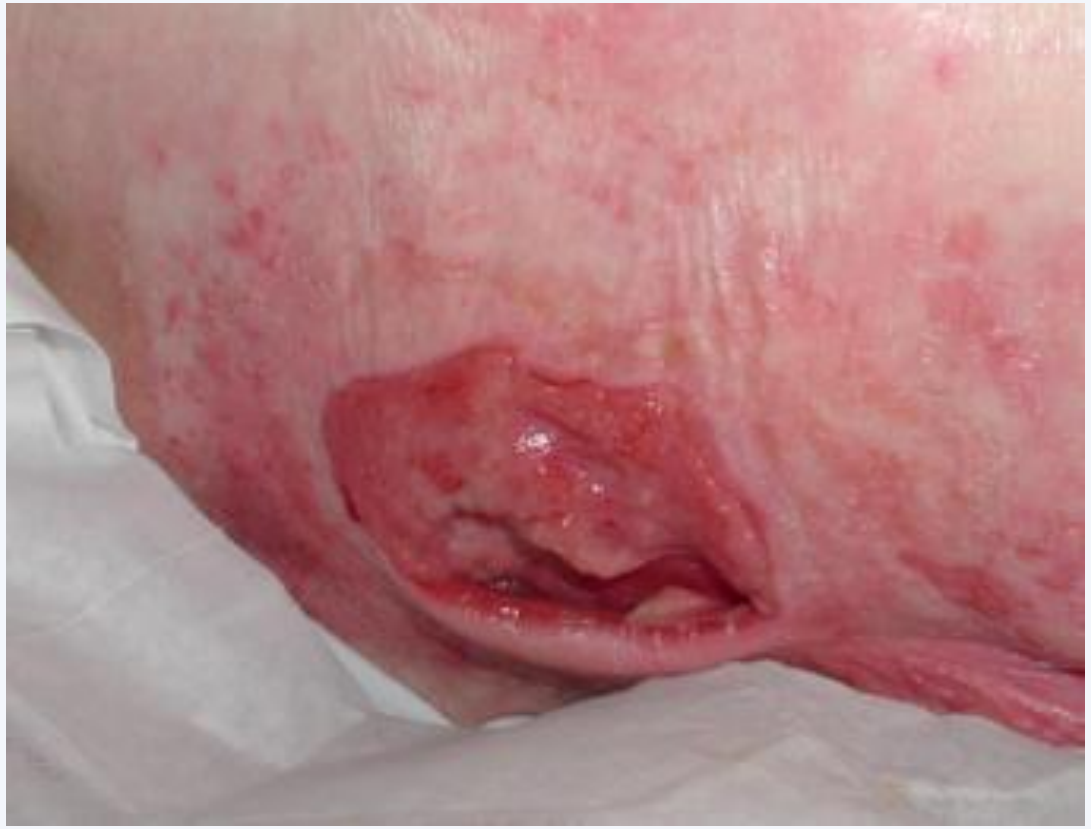
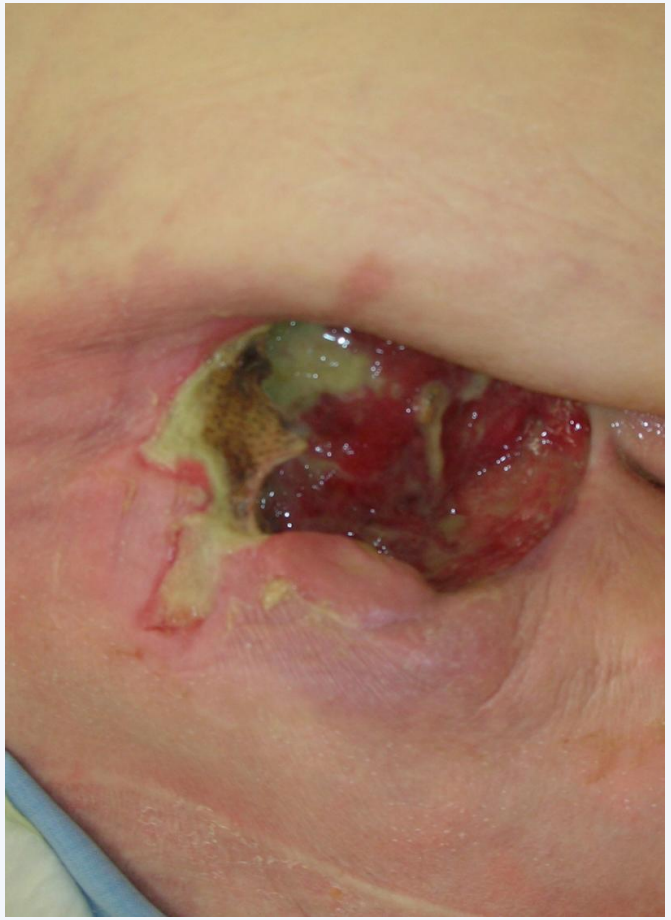
- Full thickness skin loss – subcutaneous fat may be visible, but bone, tendon or muscle are *not* exposed.
- Slough may be present but does not obscure the depth of tissue loss.
- May include undermining and tunnelling.
- The depth of a Category 3 pressure ulcer varies by anatomical location.



Category 4 Pressure Ulcer:

- Full thickness tissue loss with exposed bone, tendon or muscle.
- Slough or eschar may be present.
- Often includes undermining and tunnelling
- The depth of a category 4 pressure ulcer varies by anatomical location.
- Category 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis more likely to occur.



Cone of Pressure:

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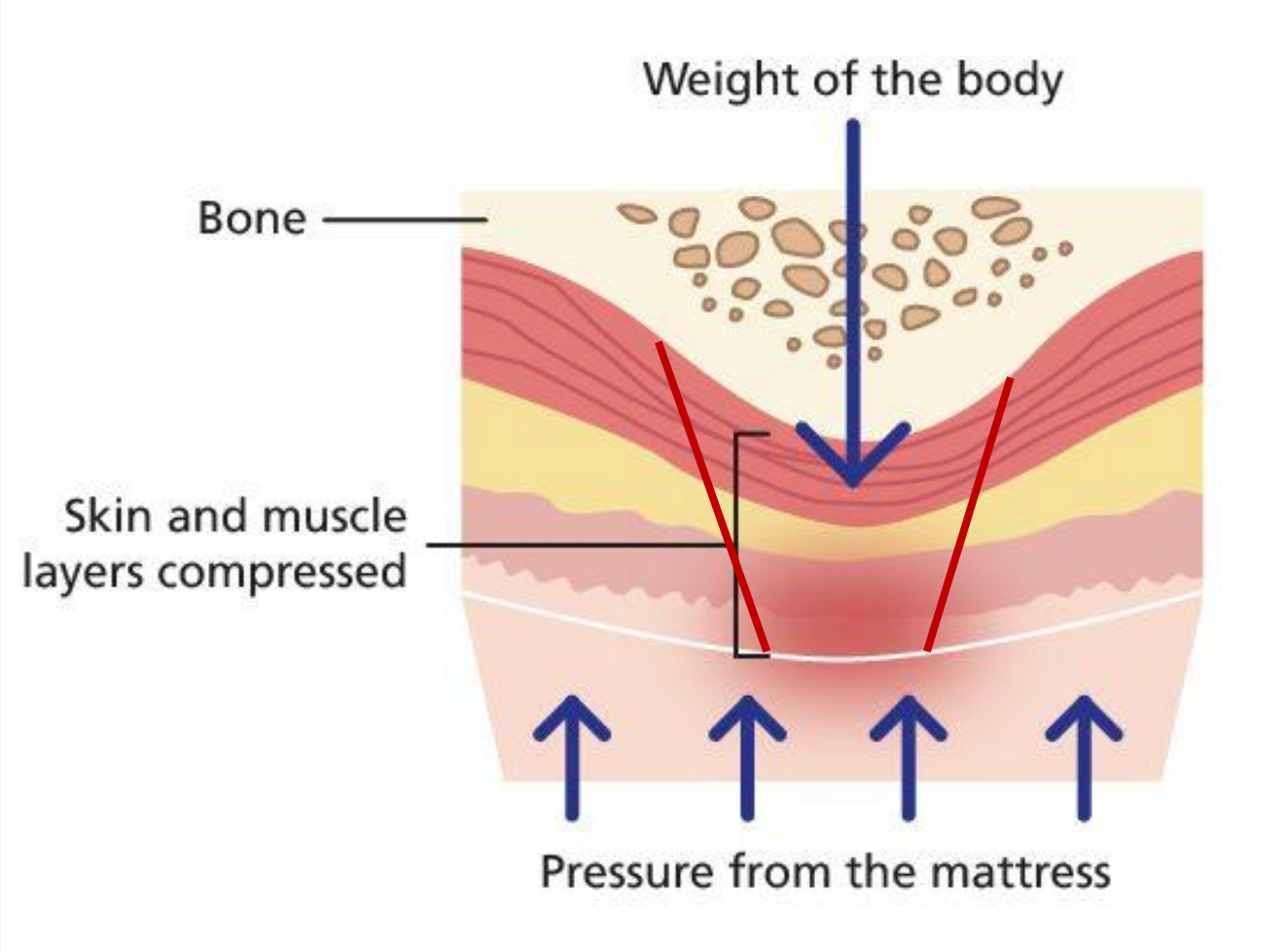

Damage spreads downwards and outwards. The wound is smaller at the surface level but wider and deeper underneath.

Normally seen in category 3 and 4 pressure damage.

Explains why wounds can deteriorate despite small surface size.

Deep Tissue Injury (DTI):

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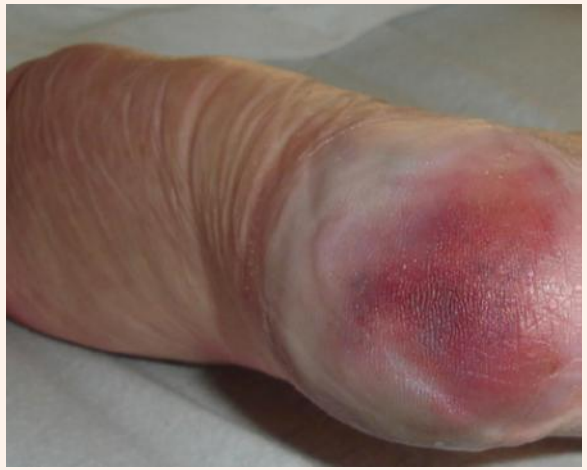
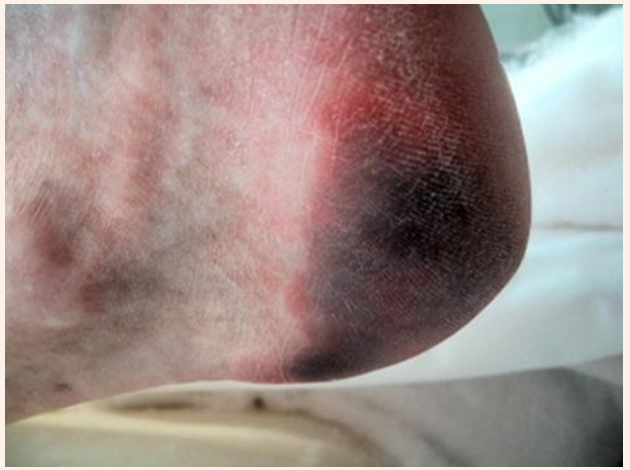
Localised area of purple/ maroon discoloured, intact skin due to damage of underlying soft tissue from pressure and/ or shear. Tissue may be ‘boggy’, warmer or cooler and more painful than adjacent tissue. Different to a bruise.





Unstageable Pressure Ulcer:

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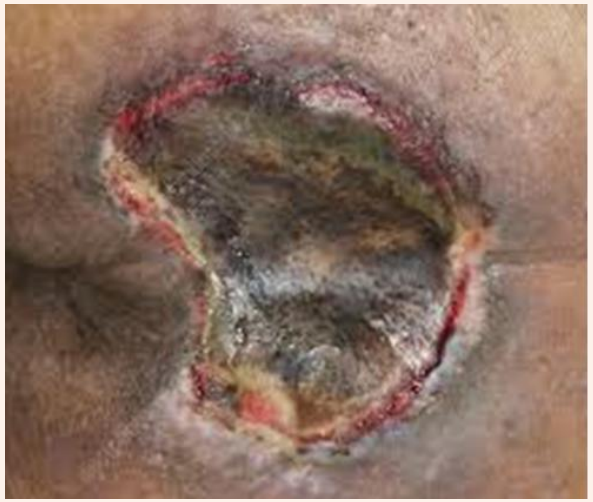
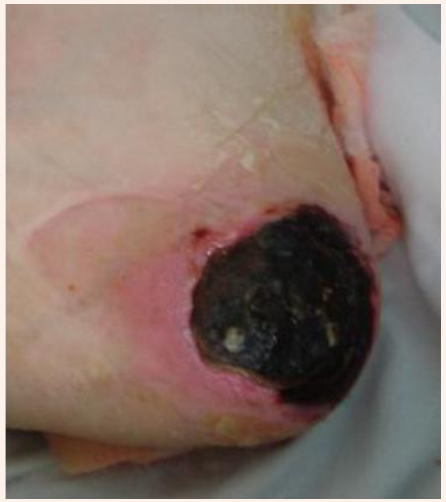
- Full thickness tissue loss in which the base of the ulcer is covered by slough and/ or eschar.
- Difficult to know the depth due presence of devitalised tissue.
- Once debrided (if your holistic assessment supports), you can resubmit category.





B E S T S H O T

Where are we likely to see pressure damage?

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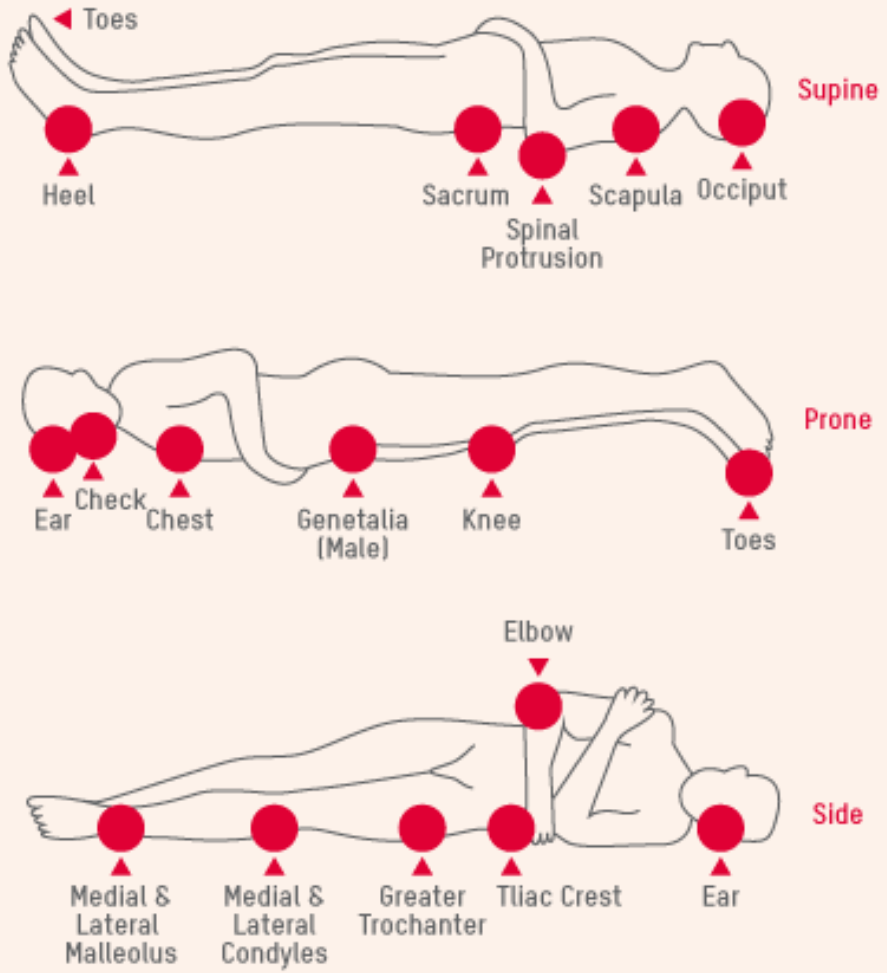

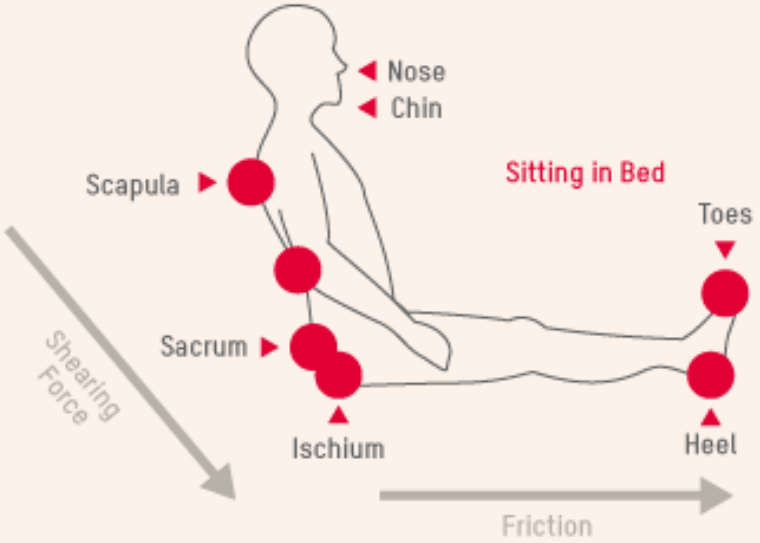

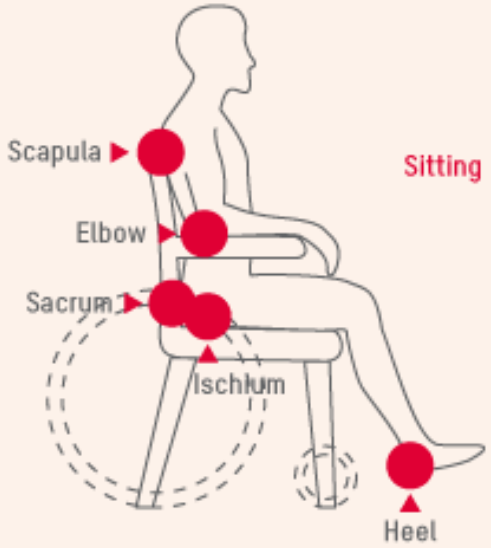

Moisture VS Pressure:

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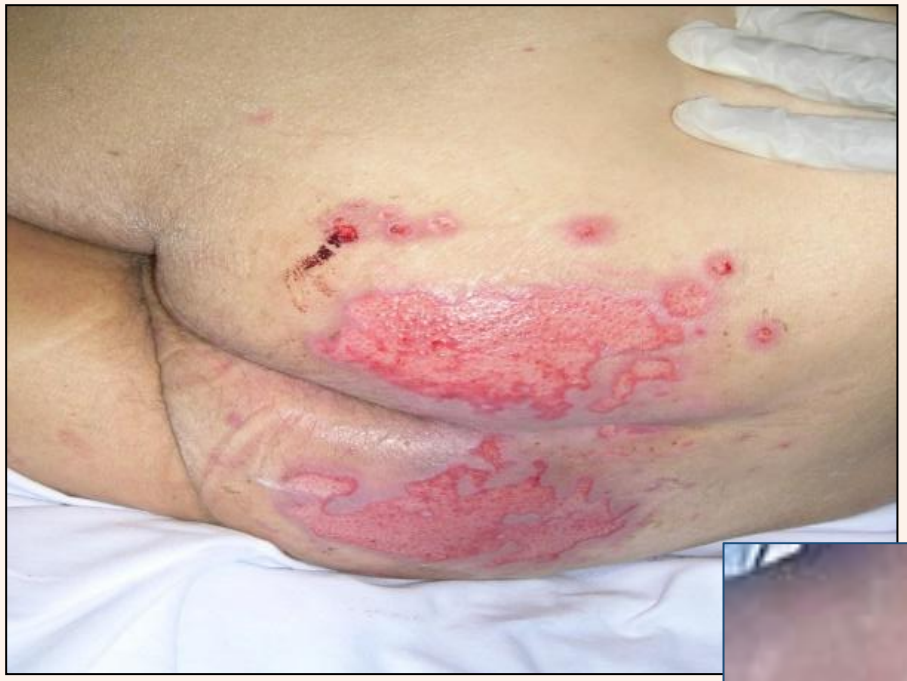
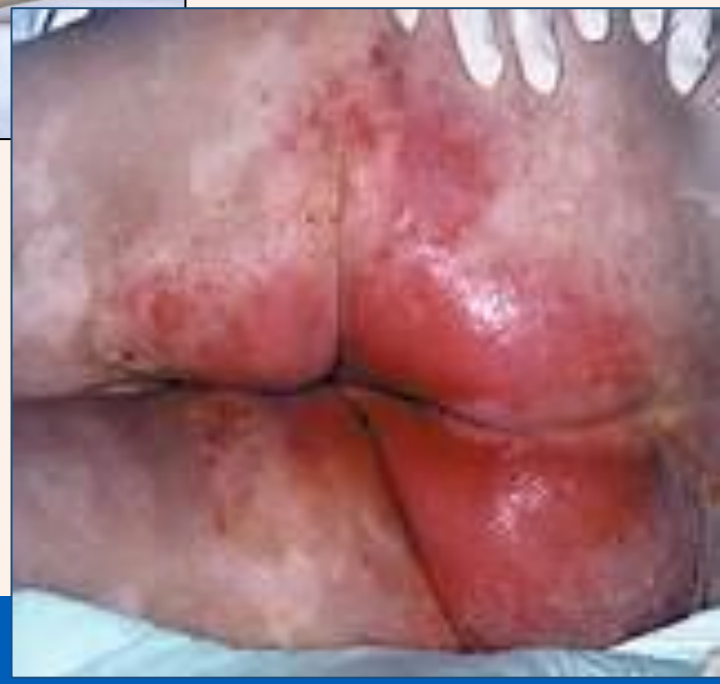
Moisture

- **Caused by Moisture being present**
- Irregular edges/ can be linear in natal cleft
- Intragluteal cleft/may be over bony prominences.
- Copy lesions/ Butterfly pattern.
- Superficial.
- No necrosis present.
- Macerated skin around the lesions.
- There can be excoriation – often associated with faecal leakage.
- Pressure/shear should be excluded.





MASD VS Pressure Damage:

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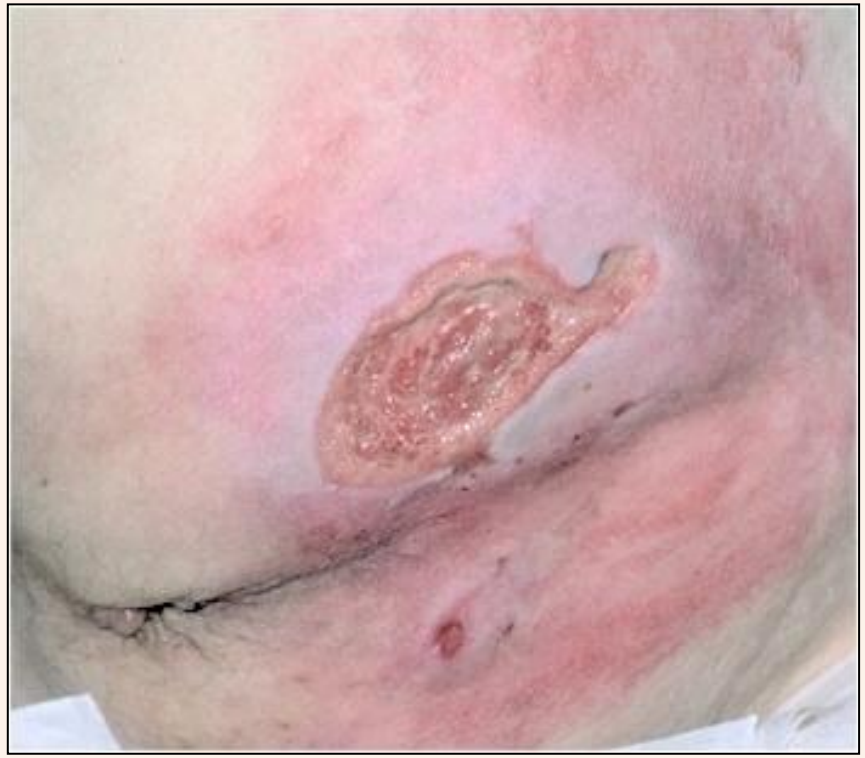
Pressure

Caused by direct pressure (ischemia) shear and friction (cell deformation).

- Defined edges circular or tear dropped shape
- Moisture is not the primary factor
- Over a bony prominence
- Slough or necrosis could be present
- Deeper lesions, particularly category 3 and 4.



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Who is at risk?

Please take a few minutes to think.

What factors put someone at risk of pressure damage?

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Who is at risk of pressure damage:

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- **Previous Pressure Damage**

- Immobility/ poor mobility,
- Seating, Positioning and Posture,
- Care environment,
- Medical Devices/ Equipment,
- Cognitive/ mental health/ mental capacity,
- Psychosocial considerations,
- Non concordance,
- Acute/Chronic illness,
- End of Life Illness (SCALE),
- Medication,
- Manual Handling/ transferring Techniques,
- Extremes of age (very old/ very young).

Incident reporting on Ulysses

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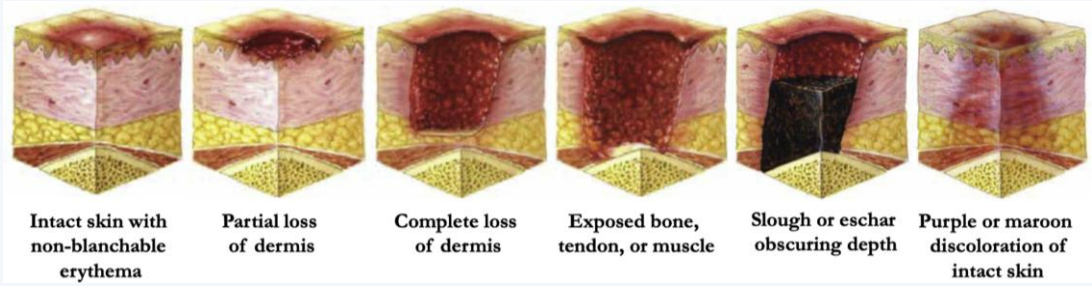
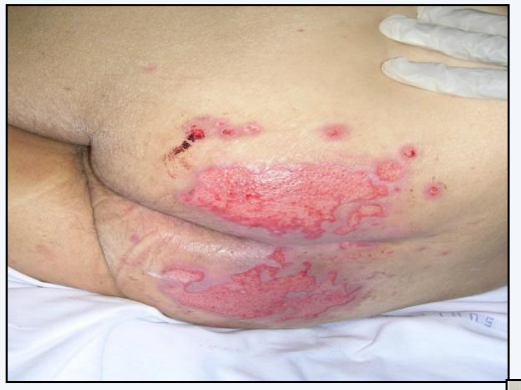
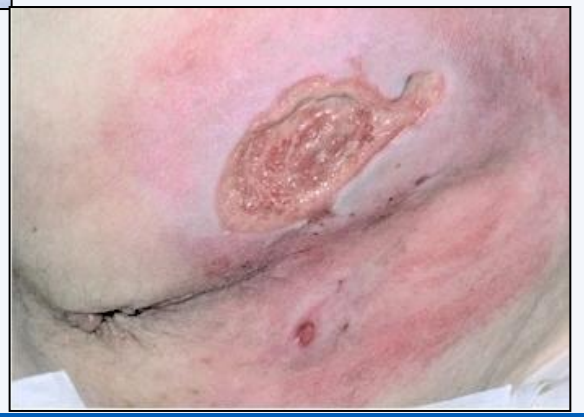
- ALL category of pressure ulcer/injury should be reported
- A PURE moisture lesion in NOT a pressure ulcer and should not be reported as one
- HOWEVER, if a pressure ulcer has a moisture element as well, when you report the pressure ulcer you add moisture as a contributing factor







No longer need to complete the questionnaires as previously.

- Patient information - age, key co-morbidities, capacity
- Service involvement with patient
- Summary of incident (Chronological order)
- BRADEN/PURPOSE-T , MUST, STRONG, aSSKINg
- pressure relieving equipment
- package of care
- Was there a care plan in place? Were there any omissions/ deviations from this?
- Was the patient concordant?
- Reason for deterioration & details

Foot ulcers & reporting

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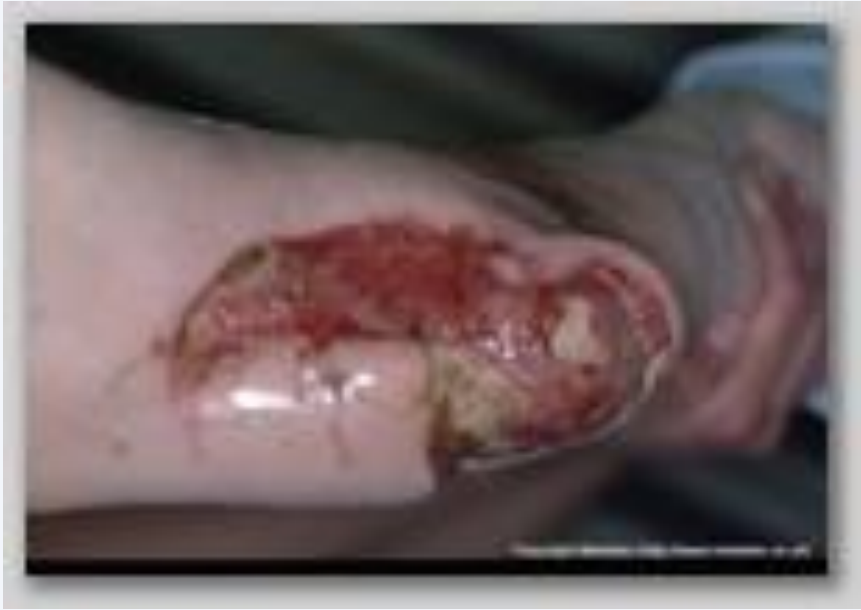
Classic pressure ulcers:

- generally caused by constant static/ shearing pressures e.g. bed bound, wheelchair, seating posture, prescribed hosiery, prescribed footwear or prescribed offloading devices
- typically found on the posterior aspect of the heel
- over bony prominences
- These ulcers should be categorised and reported as a pressure ulcer.



If a foot ulcer is not due to constant or intermittent pressure caused by constant static/shearing pressures (see examples above) then it does not need to be reported as a pressure ulcer.

The aSSKINg Care Bundle

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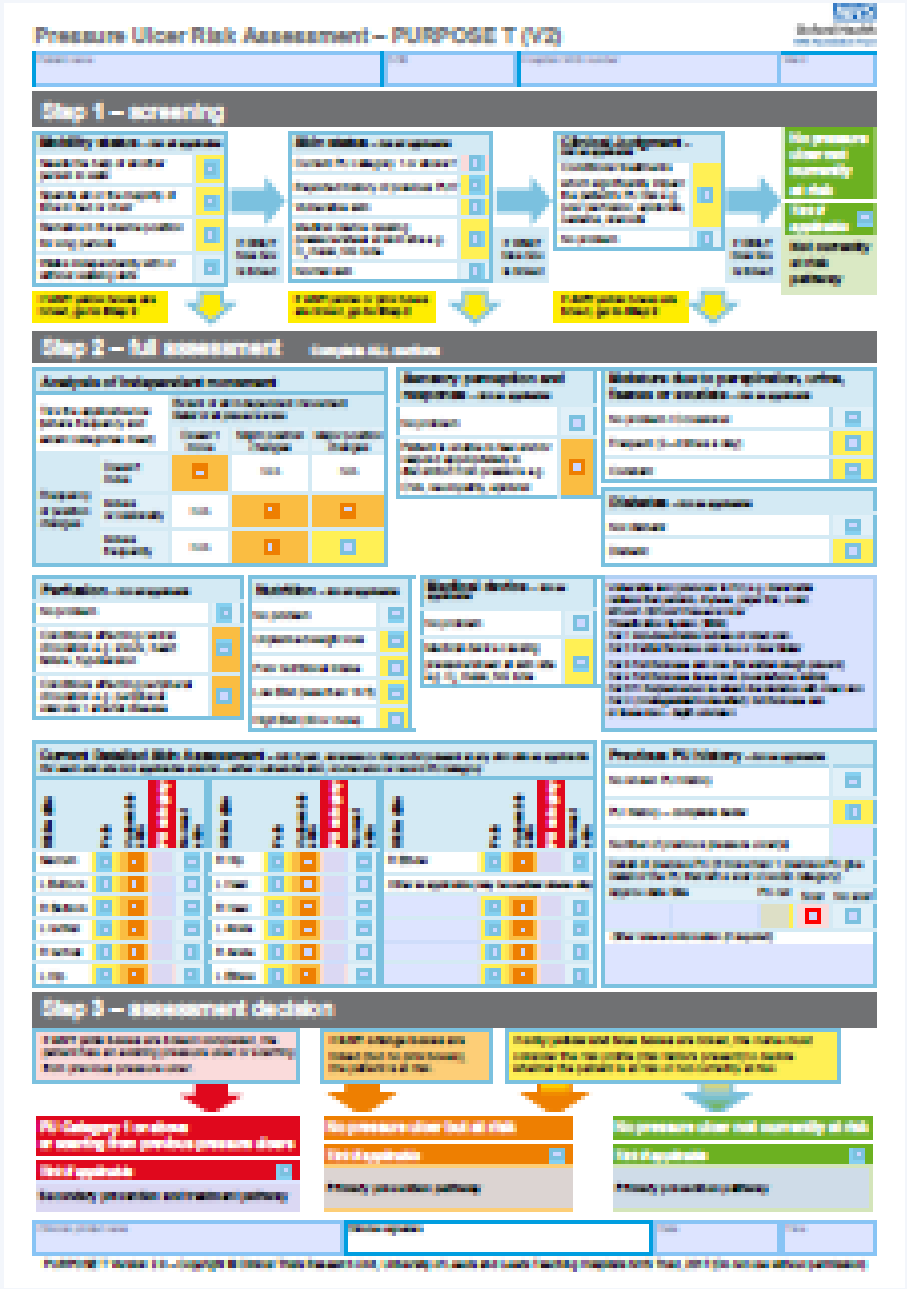
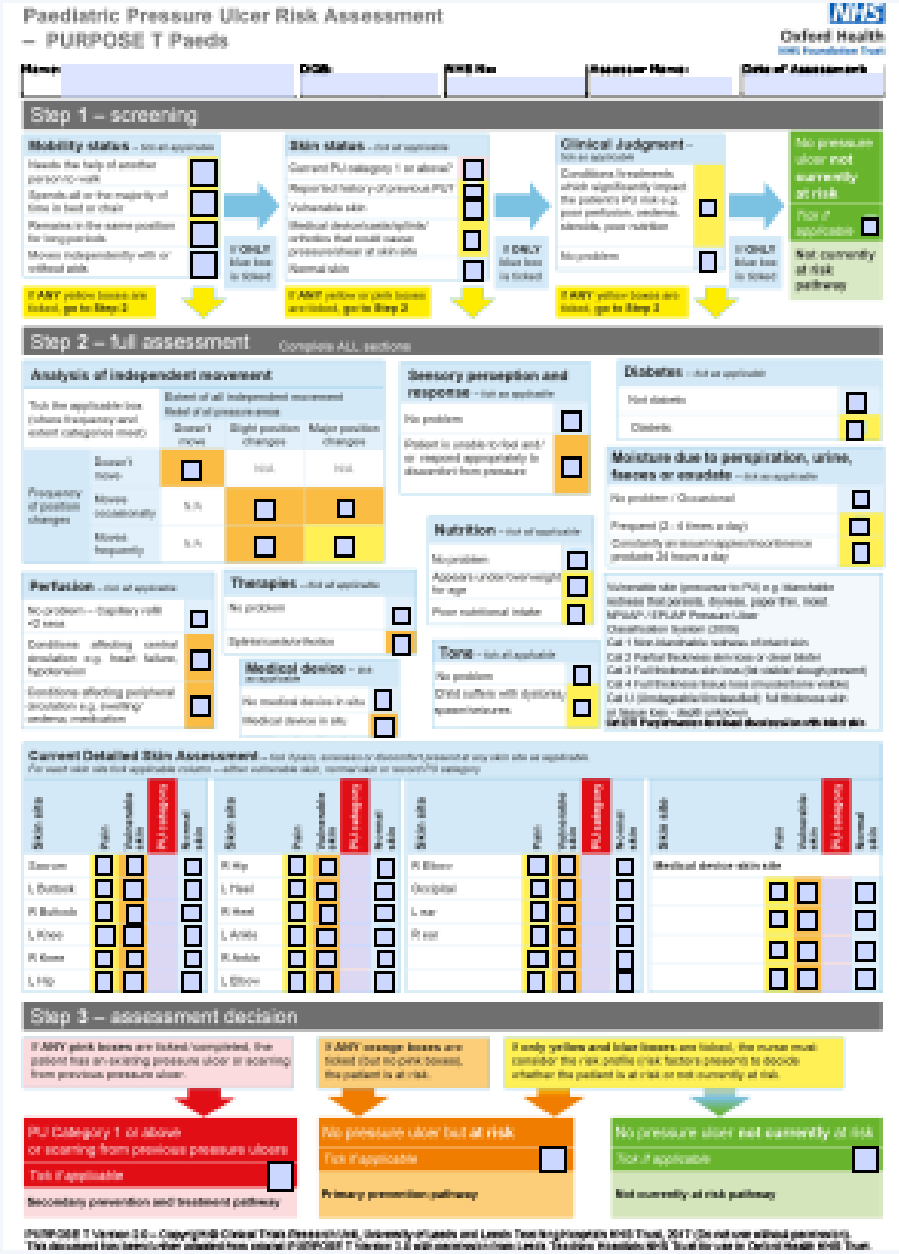
A **care bundle** is a small, structured group of evidence-based interventions (typically three to five) that, when performed together and consistently, improve patient outcomes more effectively than if they were delivered individually (IHI, 2001)

- ✓**a** = ASSESSMENT
- ✓**S** = SKIN INSPECTION
- ✓**S** = SURFACE
- ✓**K** = KEEP MOVING
- ✓**I** = INCONTINANCE / MOISTURE
- ✓**N** = NUTRITION
- ✓**g** = GIVING INFORMATION

Pressure Ulcer Risk Primary Or Secondary Evaluation - Tool.





Caring, safe and excellent

PURPOSE-T

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Consists of 3 steps:

- **Step 1:** Screening
- **Step 2**: Full assessment
- **Step 3**: Assessment decision (placing on a pathway)

Screening, & if indicated, full assessment should take place:

- within 6 hours of admission
- on change of condition, environment or circumstance
- at least weekly in hospital care
- at least monthly in community or care home

STEP 1 - SCREENING

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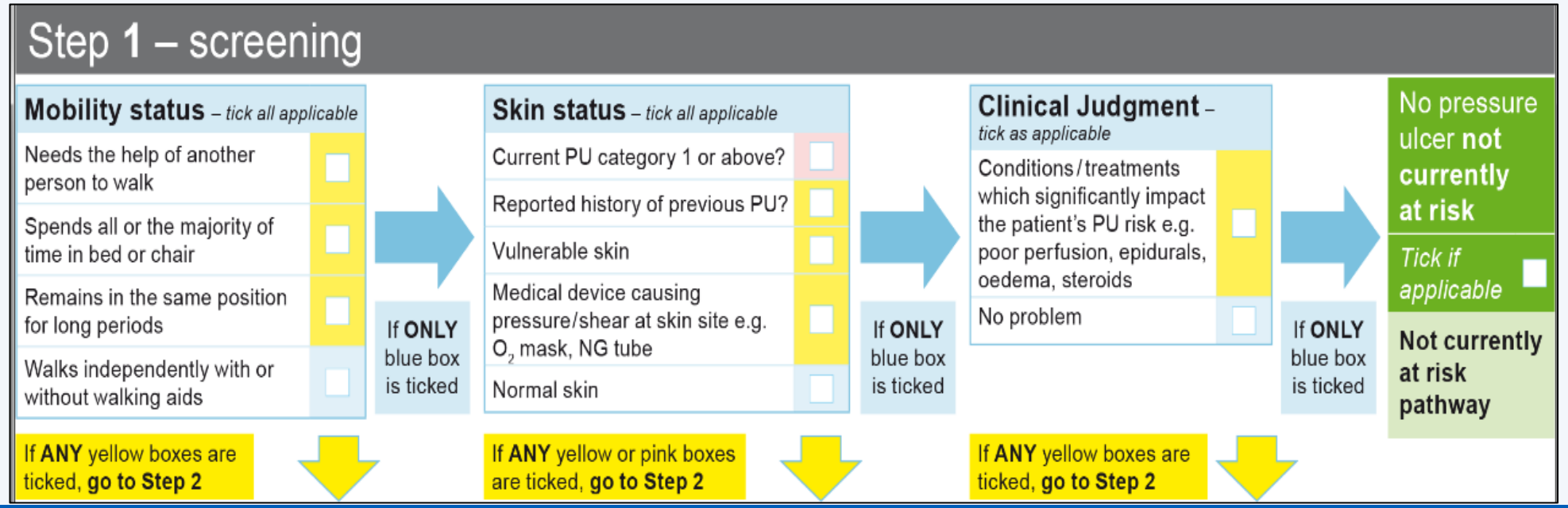
- ✓ Mobility
- ✓ skin status
- ✓ clinical judgement.

- **If a yellow or pink category is selected, clinicians should proceed to the assessment stage.**

This is the same for adults & children.

More than 1 option can be selected.



Mobility status – *tick all applicable*	
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	☐
Walks independently with or without walking aids	☐

If **ANY** yellow boxes are ticked, **go to Step 2**

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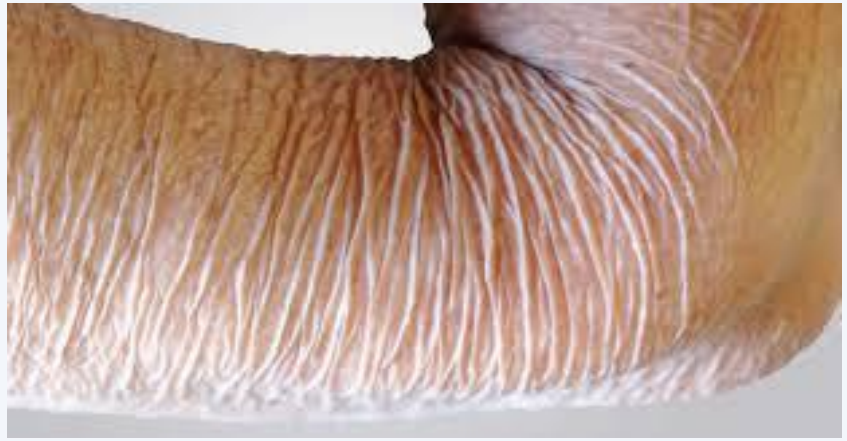
More than 1 option can be selected.

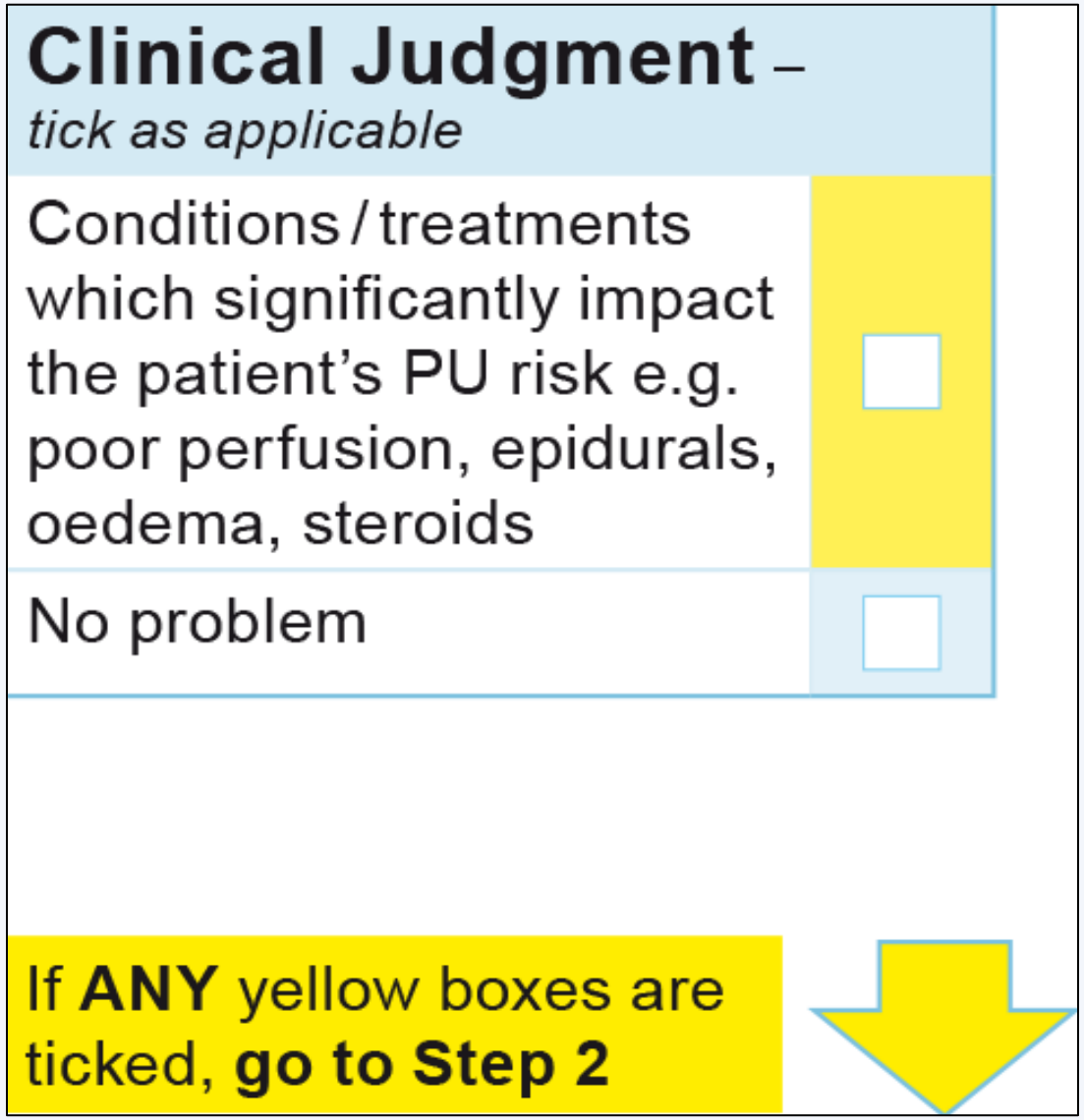
Skin status – *tick all applicable*	
Current PU category 1 or above?	☐
Reported history of previous PU?	☐
Vulnerable skin	☐
Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube	☐
Normal skin	☐

If **ANY** yellow or pink boxes are ticked, **go to Step 2**



More than 1 option can be selected.

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.



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- Poor perfusion – arterial disease
- Neuropathy – lack of sensation
- Neurological conditions – stroke, MS, MND, Parkinsons
- Sedation/anaesthetic
- Lymphoedema
- Diabetes
- Cognitive impairment
- Extremes of age

Step 2: Full Assessment

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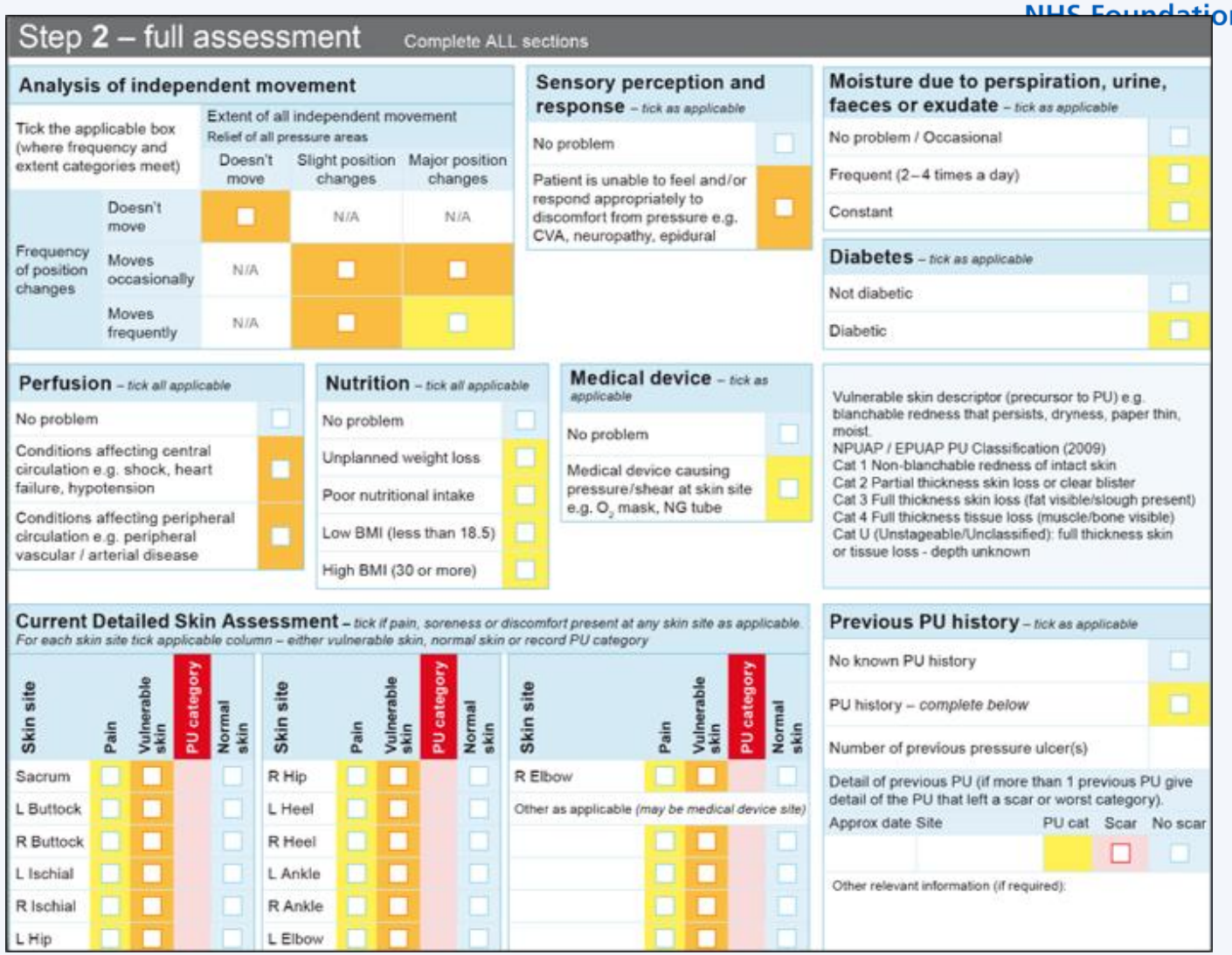
The ADULT full assessment stage comprises of:

- **independent movement**
- **sensory perception**
- **moisture**
- **diabetes**
- **perfusion**
- **nutrition**
- **medical devices**
- **detailed skin assessment**
- **previous pressure ulcer history**



Step 2 – full assessment Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem ☐
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural ☐

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) ☐

Medical device – *tick as applicable*

- No problem ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐

Vulnerable skin descriptor (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP PU Classification (2009)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown

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

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Other as applicable *(may be medical device site)*				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

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).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Paediatric PURPOSE-T - STEP 2

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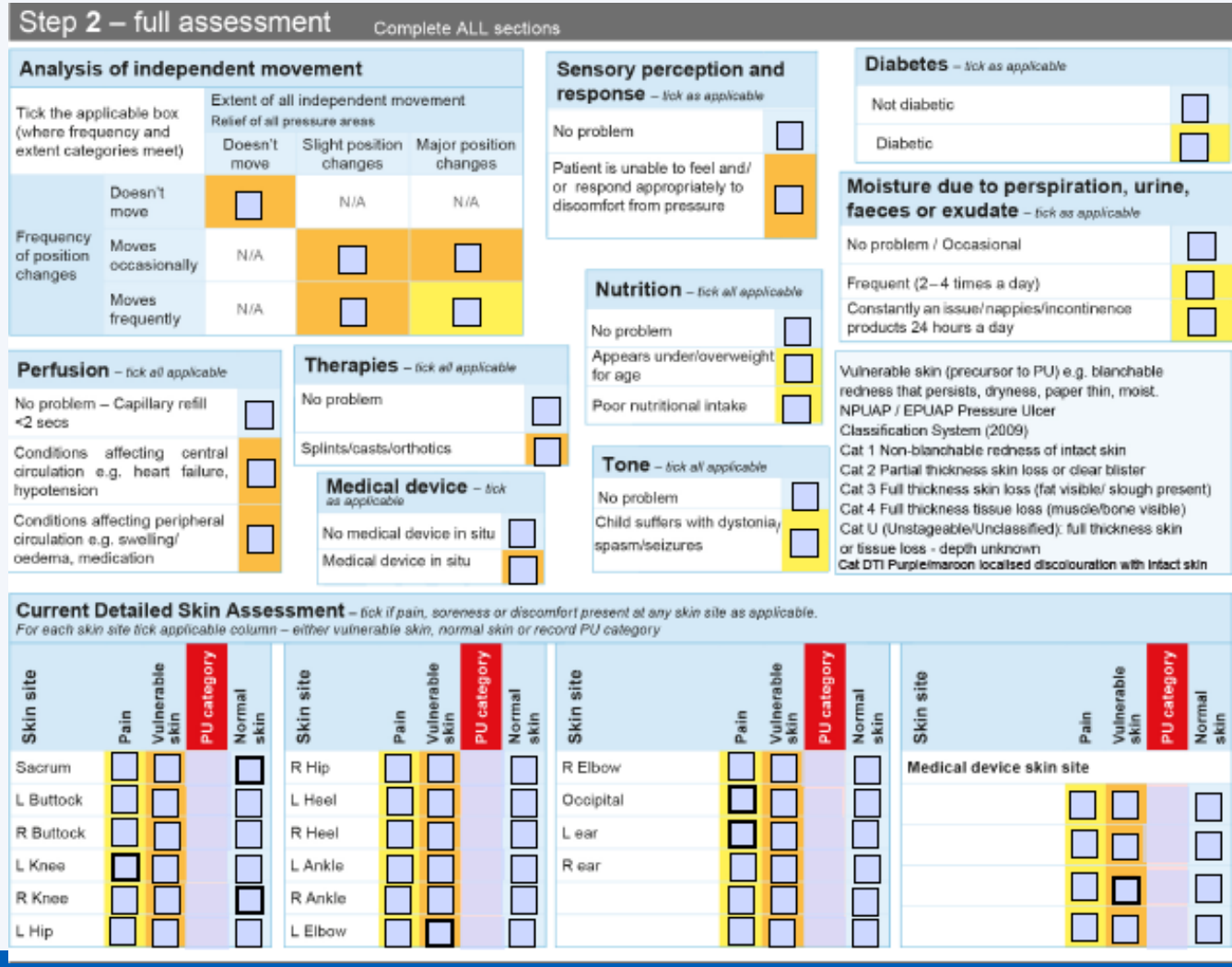
- Independent movement
- Sensory perception
- Moisture
- Diabetes
- Perfusion
- Nutrition
- Medical device
- Detailed skin assessment
- Tone
- Therapies



Step 2 – full assessment — Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Extent of all independent movement — Relief of all pressure areas

Frequency of position changes	Doesn't move	Slight position changes	Major position changes
Doesn't move		N/A	N/A
Moves occasionally	N/A		
Moves frequently	N/A		

Sensory perception and response – *tick as applicable*

- No problem
- Patient is unable to feel and/ or respond appropriately to discomfort from pressure

Diabetes – *tick as applicable*

- Not diabetic
- Diabetic

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional
- Frequent (2–4 times a day)
- Constantly an issue/nappies/incontinence products 24 hours a day

Nutrition – *tick all applicable*

- No problem
- Appears under/overweight for age
- Poor nutritional intake

Perfusion – *tick all applicable*

- No problem – Capillary refill <2 secs
- Conditions affecting central circulation e.g. heart failure, hypotension
- Conditions affecting peripheral circulation e.g. swelling/ oedema, medication

Therapies – *tick all applicable*

- No problem
- Splints/casts/orthotics

Medical device – *tick as applicable*

- No medical device in situ
- Medical device in situ

Tone – *tick all applicable*

- No problem
- Child suffers with dystonia/ spasm/seizures

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Cat DTI Purple/maroon localised discolouration with intact skin

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

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum				
L Buttock				
R Buttock				
L Knee				
R Knee				
L Hip				

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip				
L Heel				
R Heel				
L Ankle				
R Ankle				
L Elbow				

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow				
Occipital				
L ear				
R ear				

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Medical device skin site				

Analysis of independent movement				
Tick the applicable box (where frequency and extent categories meet)		Extent of independent movement Relief of all pressure areas		
		Doesn't move	Slight position changes	Major position changes
Frequency of position changes	Doesn't move	☐	N/A	N/A
	Moves occasionally	N/A	☐	☐
	Moves frequently	N/A	☐	☐

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Consider the persons ability to move **independently; how often they move and to what extent.**

Sensory perception

Sensory perception and response – *tick as applicable*	
No problem	☐
Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural	☐

Children's version doesn't give examples.

Moisture

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ADULTS

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

CHILDREN

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*	
No problem / Occasional	☐
Frequent (2–4 times a day)	☐
Constantly an issue/nappies/incontinence products 24 hours a day	☐

Diabetes

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Diabetes - *tick as applicable*	
Not diabetic	☐
Diabetic	☐

Perfusion

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ADULTS

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

CHILDREN

Perfusion – *tick all applicable*	
No problem – Capillary refill <2 secs	☐
Conditions affecting central circulation e.g. heart failure, hypotension	☐
Conditions affecting peripheral circulation e.g. swelling/ oedema, medication	☐

Nutrition

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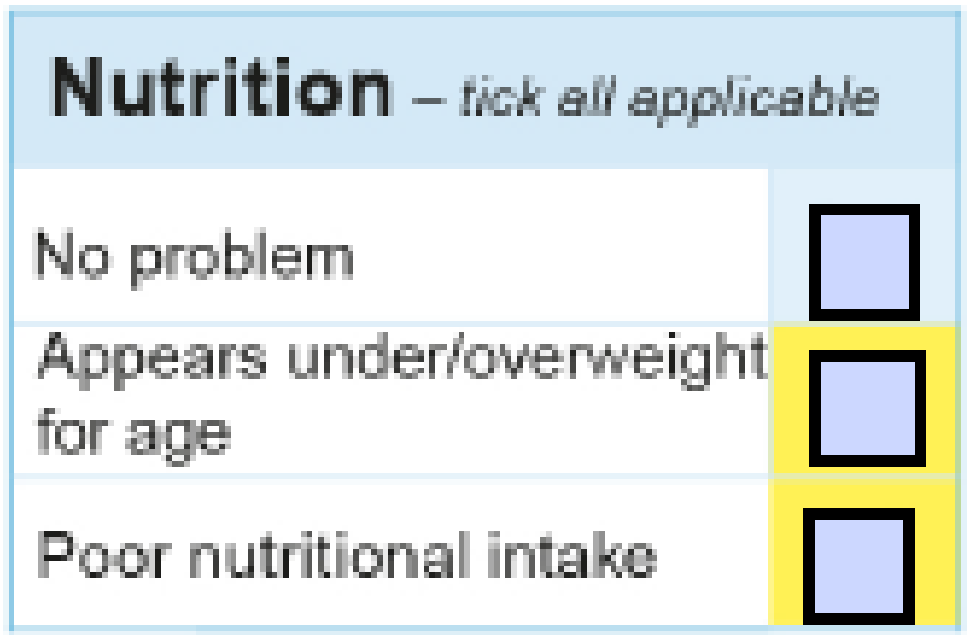
ADULTS

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

CHILDREN'S



Medical device

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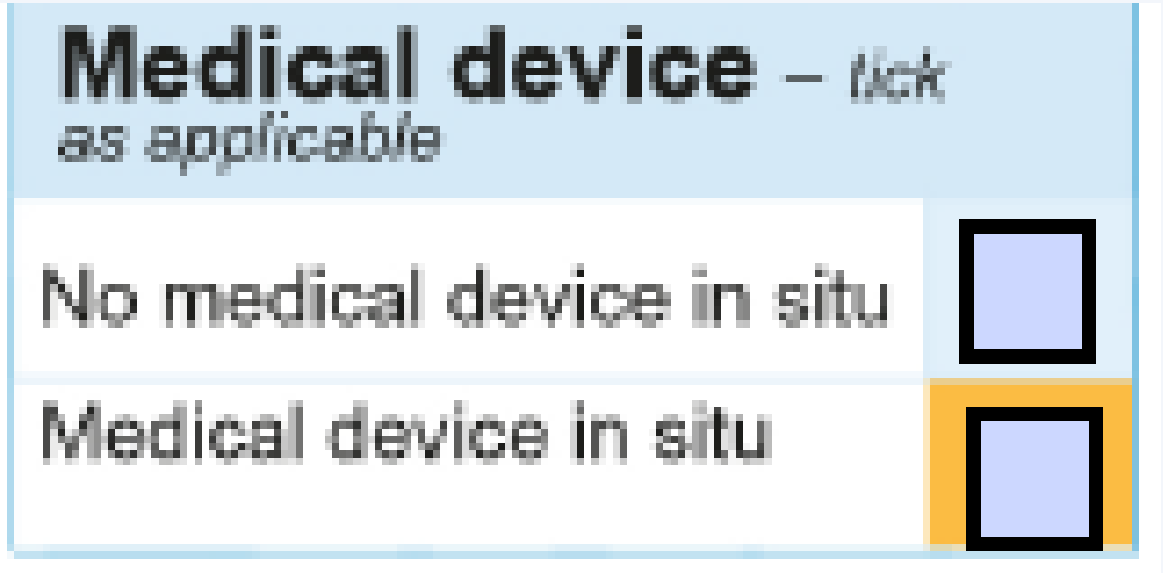
ADULTS

Medical device – *tick as applicable*	
No problem	☐
Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube	☐

CHILDREN

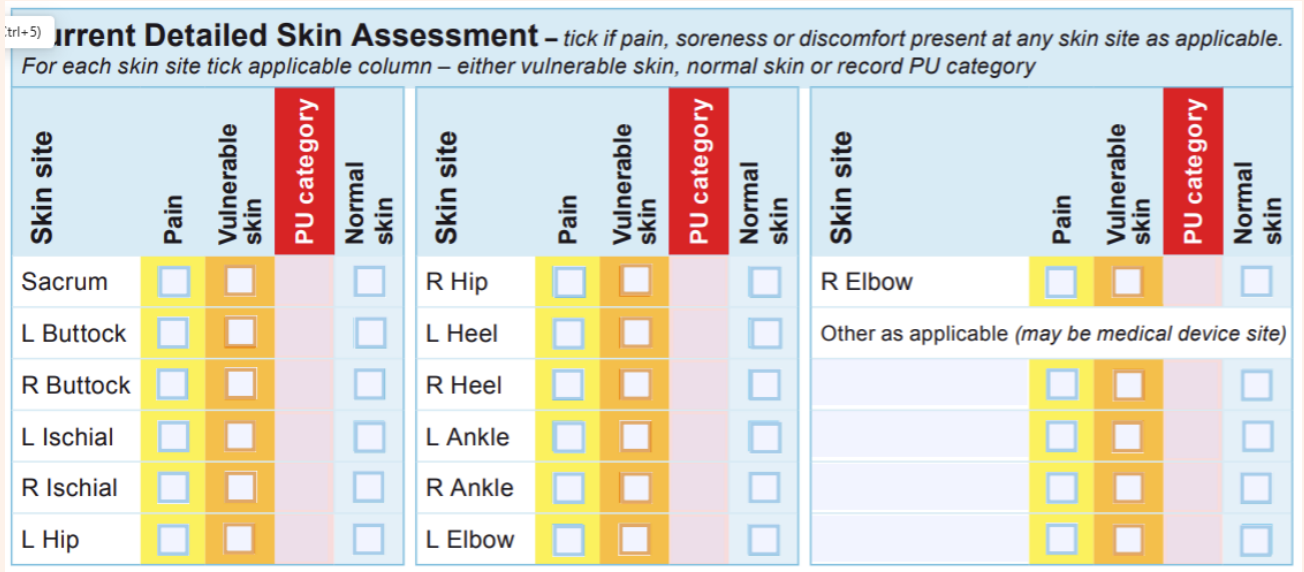


Previous PU history *tick as applicable*				
No known PU history				☐
PU history - *complete below*				☐
Number of previous pressure ulcer(s):				
Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).				
Approx date	Site	PU cat	Scar	No scar
			☐	☐
Other relevant information (if required):				

- Adults only
- Previous PU – yellow
- Scar from previous PU pink

Detailed skin assessment:

- A systematic approach to inspecting all pressure areas and recording:
  - Pain or discomfort,
  - Vulnerable skin.
  - Pressure Ulcer Category.
  - Normal skin,



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

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum				
L Buttock				
R Buttock				
L Ischial				
R Ischial				
L Hip				

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip				
L Heel				
R Heel				
L Ankle				
R Ankle				
L Elbow				

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow				
Other as applicable *(may be medical device site)*				

How to use this tool:

- Inspect every listed skin site – don't assume.
- Ask the patient about pain or soreness – this may be the earliest sign of damage.
- Tick one option per site.

What counts as vulnerable skin?

- Red, purple, blue, maroon, or grey discolouration,
- Non-blanching areas,
- Boggy, firm, shiny or fragile skin,
- Moist or macerated skin,
- Skin that is painful, warm or cool.

ADULTS

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

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Other as applicable *(may be medical device site)*				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*
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L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Knee	☐	☐		☐
R Knee	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Occipital	☐	☐		☐
L ear	☐	☐		☐
R ear	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Medical device skin site				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

CHILDREN

3 extra:

- Occiput
- Left ear
- Right ear

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Step 3: Assessment decision

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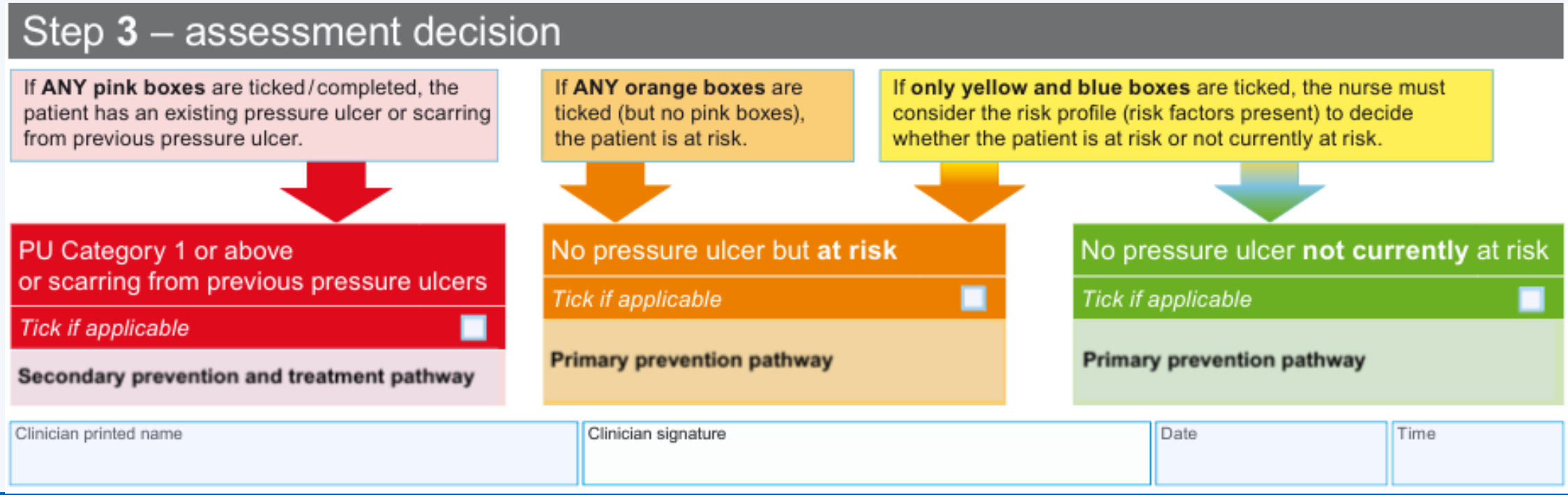
The final step of PURPOSE-T requires consideration of step 2 responses to inform 1 of 3 assessment decisions depending on the colour of boxes ticked:

- 'no pressure ulcer not currently at risk',
- 'no pressure ulcer but at risk'
- 'pressure ulcer category 1 or above or scarring from previous pressure ulcer'.



The Clinical Pathway

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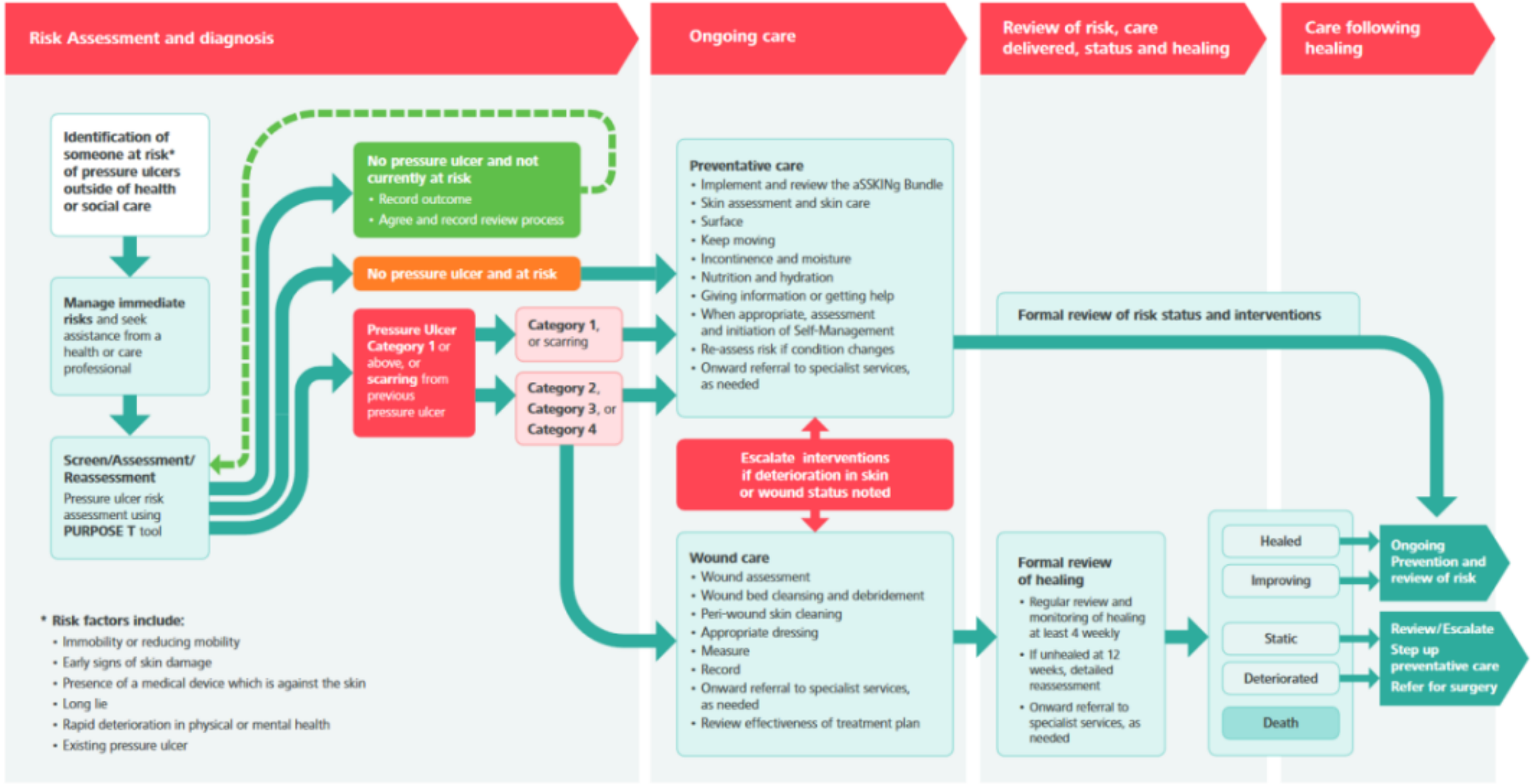

PURPOSE-T CASE STUDY

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Select from one of the below case studies uploaded at the beginning of the CHAT

A. **Community ADULT**
B. **Community CHILD**
C. **Mental Health In-patient ADULT**

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- ✓**a** = ASSESSMENT
- ✓**S** = **SKIN INSPECTION**
- ✓**S** = SURFACE
- ✓**K** = KEEP MOVING
- ✓**I** = INCONTINANCE / MOISTURE
- ✓**N** = NUTRITION
- ✓**g** = GIVING INFORMATION

Skin Inspection – top to toe & front to back

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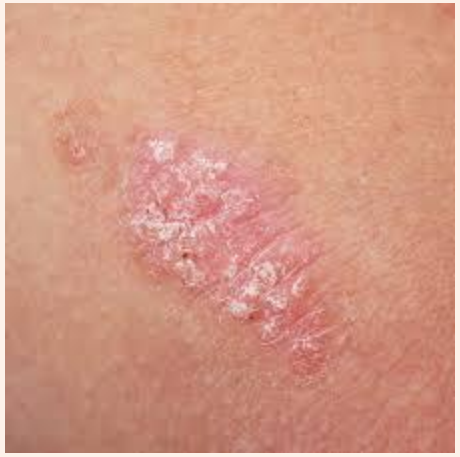
An assessment of the skin includes more than just what you can see. Use your senses of sight, touch, hearing and smell.

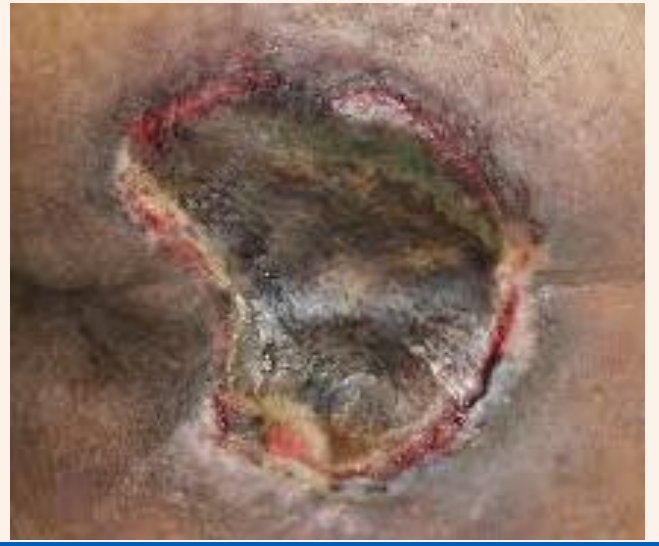
Any skin conditions? Check skin folds.

- Dry skin
- Moist
- Any signs of pressure



Consider colour, texture and temperature of the skin.

- ❖Red and discoloured - Does the area blanch?
- ❖Hot compared with the surrounding area
- ❖Hard and tight?
- ❖"Boggy" (soft and squelchy)
- ❖Cold compared with the surrounding area
- ❖painful, itchy, uncomfortable or numb.



Wound assessment & categorisation

Skin care

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Where people can, enable them to care for their own skin.

The skin can be protected by:

- keeping it clean and dry
- Use an emollient as a soap substitute
- leave on emollient – older skin with urea
- using an appropriate skin barrier
- keeping hydrated

Refer to wound formulary for dressings selection.

Surface

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- What is a surface?
- Identify all surfaces relevant to your patient - including, but not limited to, beds, mattresses, chairs, cushions, wheelchairs, vehicles, medical devices and offloading devices/orthotics
- Assess the **nature of the surface** and the **length of time** someone spends in contact with it.
- If skin changes occur or the patient is reporting pain or discomfort due to pressure then, if more frequent repositioning has not improved the situation, a change in the equipment may be needed.

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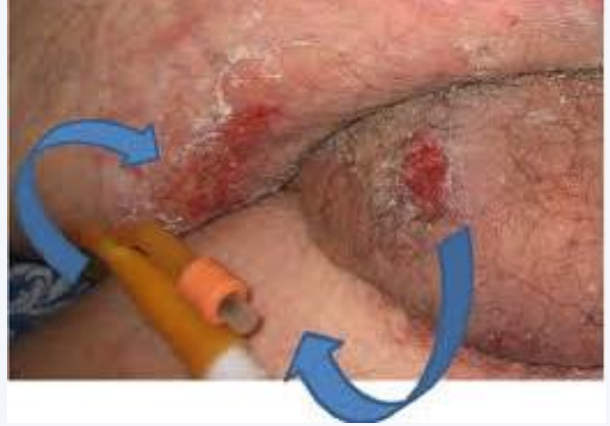
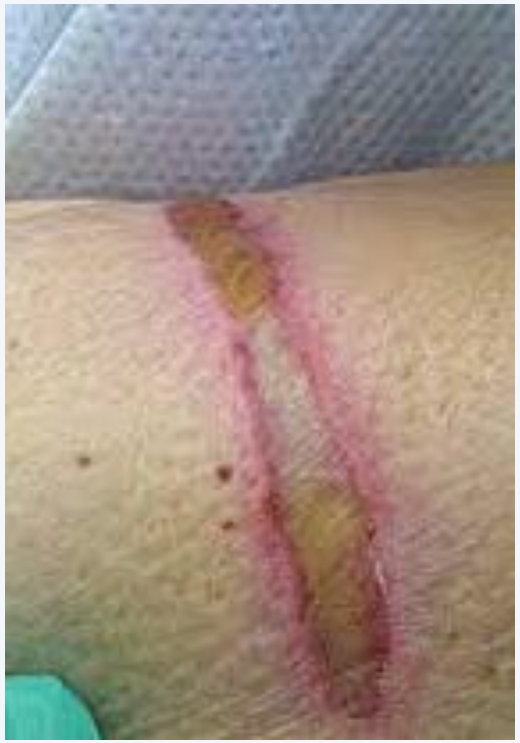
Caring, safe and excellent

Medical devices

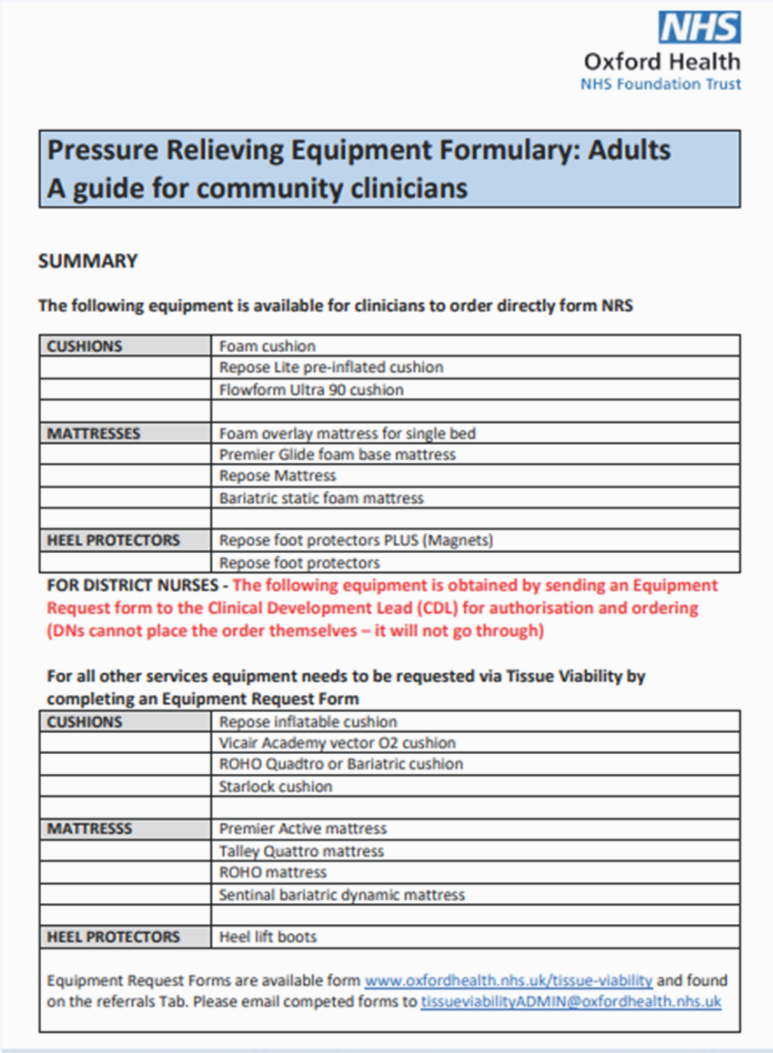
- Any device in contact with the skin can cause pressure and result in skin ischaemia.
- Include a schedule for inspecting the skin beneath the device.
- Move the position of the device where this is possible.
- Pressure reducing skin contact layer – Dermisplus Prevent.





Pressure Relieving Equipment

- Consider the range of available equipment, including the mechanism of action, benefits and associated risks – height of bed/chair
- Consider the impact on the patient's level of independence while managing the risk of pressure ulcer development
- Choose and select the appropriate equipment for the patient's needs.
- Mental health and Community hospitals using own equipment



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Pressure Relieving Equipment Formulary: Adults
A guide for community clinicians

SUMMARY

The following equipment is available for clinicians to order directly form NRS

CUSHIONS	Foam cushion
	Repose Lite pre-inflated cushion
	Flowform Ultra 90 cushion
MATTRESSES	Foam overlay mattress for single bed
	Premier Glide foam base mattress
	Repose Mattress
	Bariatric static foam mattress
HEEL PROTECTORS	Repose foot protectors PLUS (Magnets)
	Repose foot protectors

FOR DISTRICT NURSES - The following equipment is obtained by sending an Equipment Request form to the Clinical Development Lead (CDL) for authorisation and ordering (DNs cannot place the order themselves – it will not go through)

For all other services equipment needs to be requested via Tissue Viability by completing an Equipment Request Form

CUSHIONS	Repose inflatable cushion
	Vicair Academy vector O2 cushion
	ROHO Quadtro or Bariatric cushion
	Starlock cushion
MATTRESSS	Premier Active mattress
	Talley Quattro mattress
	ROHO mattress
	Sentinal bariatric dynamic mattress
HEEL PROTECTORS	Heel lift boots

Equipment Request Forms are available form www.oxfordhealth.nhs.uk/tissue-viability and found on the referrals Tab. Please email competed forms to tissueviabilityADMIN@oxfordhealth.nhs.uk

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The following equipment is available for clinicians to order directly form Millbrook:

CUSHIONS	Foam cushion
	Repose Lite pre-inflated cushion
MATTRESSES	Foam overlay mattress for single bed
	Premier Glide foam base mattress
	Repose Mattress
	Bariatric static foam mattress
HEEL PROTECTORS	Repose foot protectors PLUS (Magnets)
	Repose foot protectors

FOR DISTRICT NURSES - The following equipment is obtained by sending an Equipment Request form to the Clinical Development Lead (CDL) for authorisation and ordering (DNs cannot place the order themselves – it will not go through)

Millbrook PINs – work in progress!!

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For all other services equipment needs to be requested via Tissue Viability by completing an Equipment Request Form

CUSHIONS	Repose inflatable cushion
	Vicair Academy vector O2 cushion
	ROHO Quadtro or Bariatric cushion
	Starlock cushion
MATTRESSS	Premier Active mattress
	OSKA Series 3 mattress (Talley Quattro still in circulation)
	ROHO mattress
	Sentinal bariatric dynamic mattress
HEEL PROTECTORS	HEELIFT® boots

Equipment Request Forms are available form www.oxfordhealth.nhs.uk/tissue-viability and found on the Contact us/Referrals Tab. Please email competed forms to tissueviabilityADMIN@oxfordhealth.nhs.uk

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TISSUE VIABILITY EQUIPMENT REQUEST FORM

For the provision of beds, mattresses, cushions and specialist chairs.

Please print clearly as the inability to read form will result in a delay.

All fields must be completed, any incomplete forms will be returned.

Please make sure you include a **mobile** telephone number which you will be available on in case Tissue viability needs to contact you.

We no longer receive FAXES so please SUBMIT via email to:

tissueviabilityADMIN@oxfordhealth.nhs.uk
(if you do not have an oxford health account),

You will get an automated confirmation of receipt.

If you urgently need to contact someone about your order, please ring Tissue viability admin on 01865 904271 / 904959.

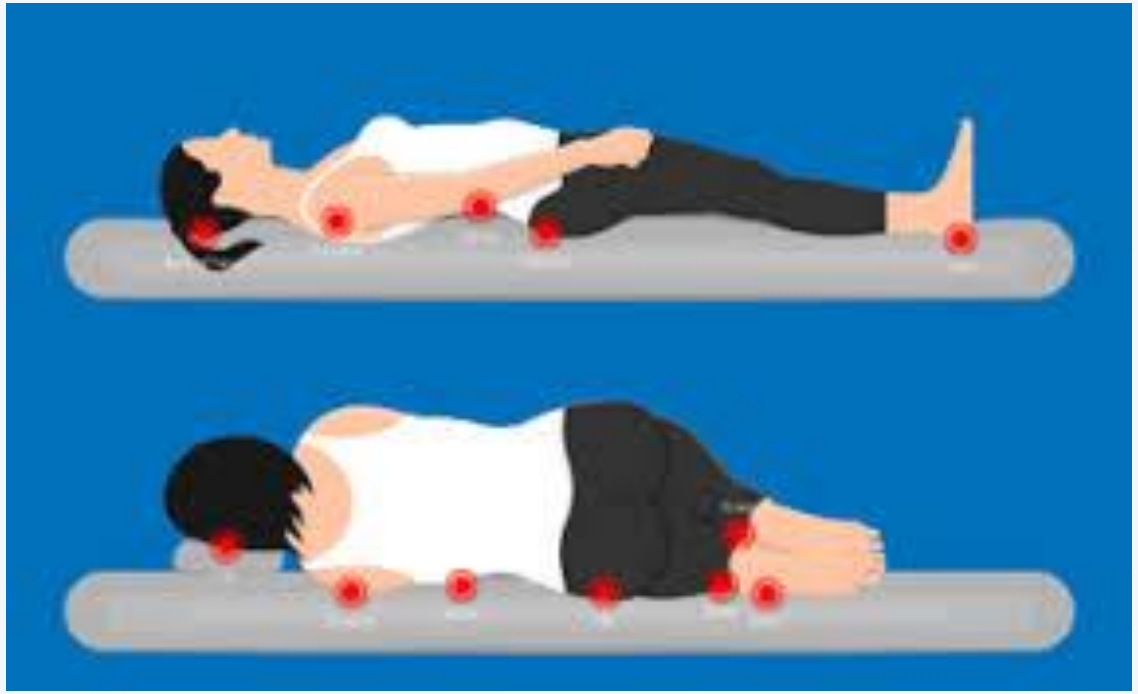
For assistance in assessing for the appropriate equipment, please refer to the following documents which are available on the Equipment tab on our website www.oxfordhealth.nhs.uk/tissue-viability

- Pressure Relieving Equipment Formulary: A guide for clinicians
- Mattress selection guide
- Cushion selection guide
- Guide for use of heel protectors
- Criteria for the supply of riser recliner chairs
- Criteria for the supply of hospital beds into residential care homes
- Frequently requested information on pressure relieving equipment

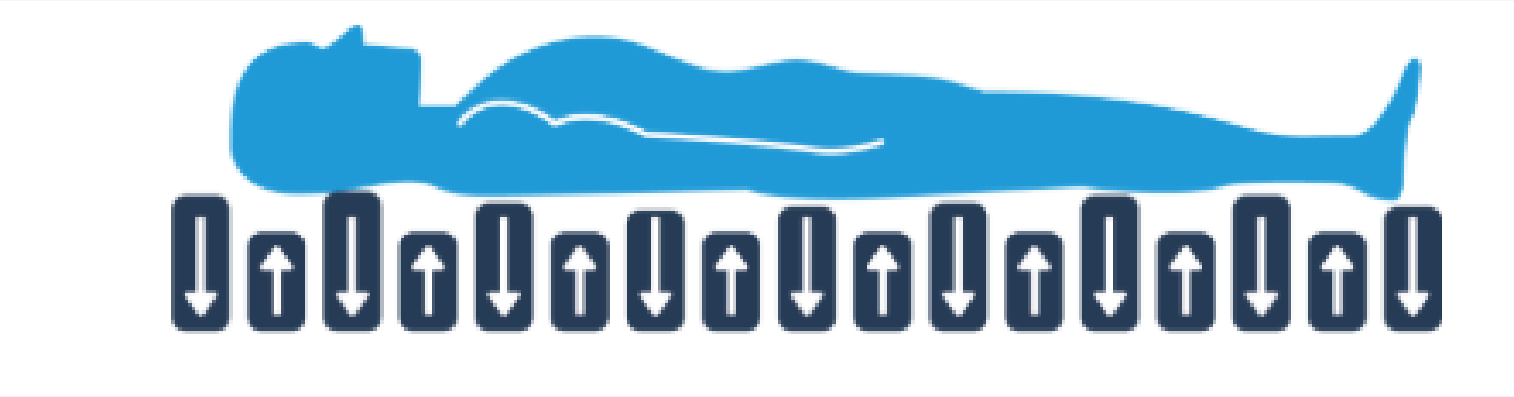
EQUIPMENT ON LOAN: Have you informed the client that this is NHS/ICES equipment on loan and they are responsible for it while it is their possession? Any neglect, damage or disposal may incur a claim from the PCT.

EQUIPMENT COLLECTION: Please note: Equipment collection will not be before 5 days after the request of collection. Please make client or family aware when discussing provision.

Am immersive surface helps redistribute pressure



Alternating & offloading



A powered mattress with alternating air cells. When a cell is deflated, all pressure is relieved from the tissues above.

The heel is suspended above a space, so no pressure is exerted.

Mattresses:

Foam Overlay:

- Low risk patients with no pressure damage and can reposition themselves.

Premier MaxiGlide:

- Patients up to moderate/high risk but can reposition themselves.
- Glide system reduces shear when on a profiling bed.

Repose Overlay:

- For up to category 2, and able to reposition themselves.
- Can be used on a patient's own bed.

Mattresses:

Premier Active 2 Hybrid:

- Patients at high risk, up to category 2 who cannot move themselves.
- Dynamic mattress encased in foam.

ROHO:

- Suitable for those with multiple areas of pressure damage up to category 4, especially those at low body weight.
- Known as dry flotation, patients are immersed into the mattress.
- Needs to be set up with the patient on it by a clinician.

OSKA series 3 or Talley Quattro

- For patients with category 3&4 pressure ulcers, or those at high risk with multiple risk factors.
- Has 3 comfort settings and a seated setting.

Mattress selection guide in the prevention and management of pressure damage

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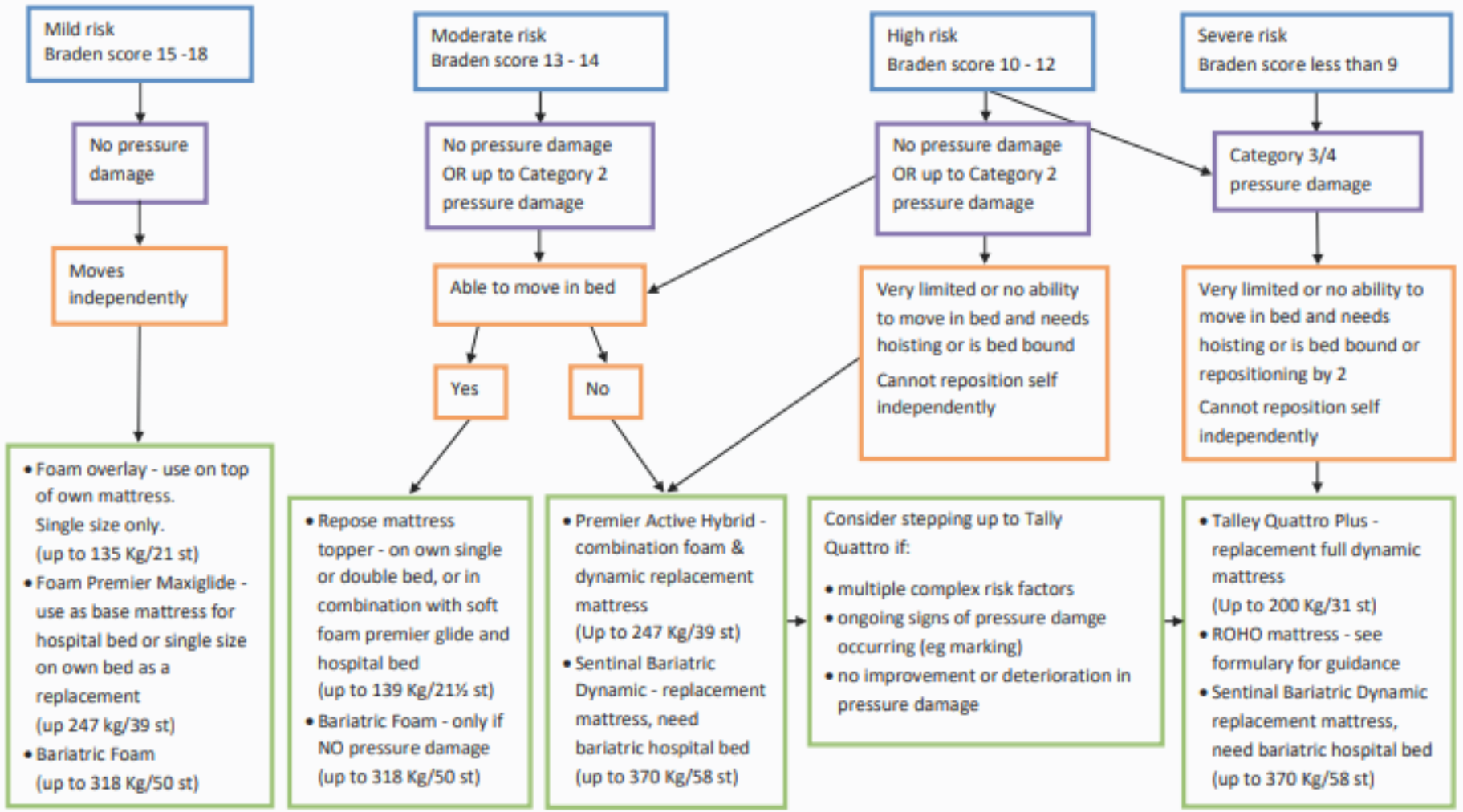

Tissue Viability/Mattress selection Guide/V3/JUNE2021

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Seating

- Those who are wheelchair-dependent refer to Oxfordshire wheelchair service.
- Cushions added to a seat can alter the sitting position of the patient.
- Those sitting in armchairs for long period may need a seating assessment to consid the height and fit of the chair for them. Having a pressure reducing cushion integrated within the chair is the best option.
- Occupational therapists can support seat assessments.

Foam Cushion:

- For low-risk patients with no pressure damage who can reposition themselves and get up independently.

Repose cushion:

- High risk, category 1-2 who can move with or without assistance.
- Good for immersion.

Cushions:

Cushions:

Vicair:

- For patients with category 3-4 pressure damage, or who are at high risk and sit for long periods.
- Ready for immediate use.

ROHO:

- For patients up to category 4 pressure damage or patients who are at high risk who sit for long periods or time or refuse to move.
- Static air, works by immersion.
- Must be set up by clinician.

Starlock:

- Uses for patients up to category 4 to offload the pressure underneath the pressure damage by locking off cells, or for posture issues.
- Must be set up by clinician.

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Cushion selection guide in the prevention and management of pressure damage

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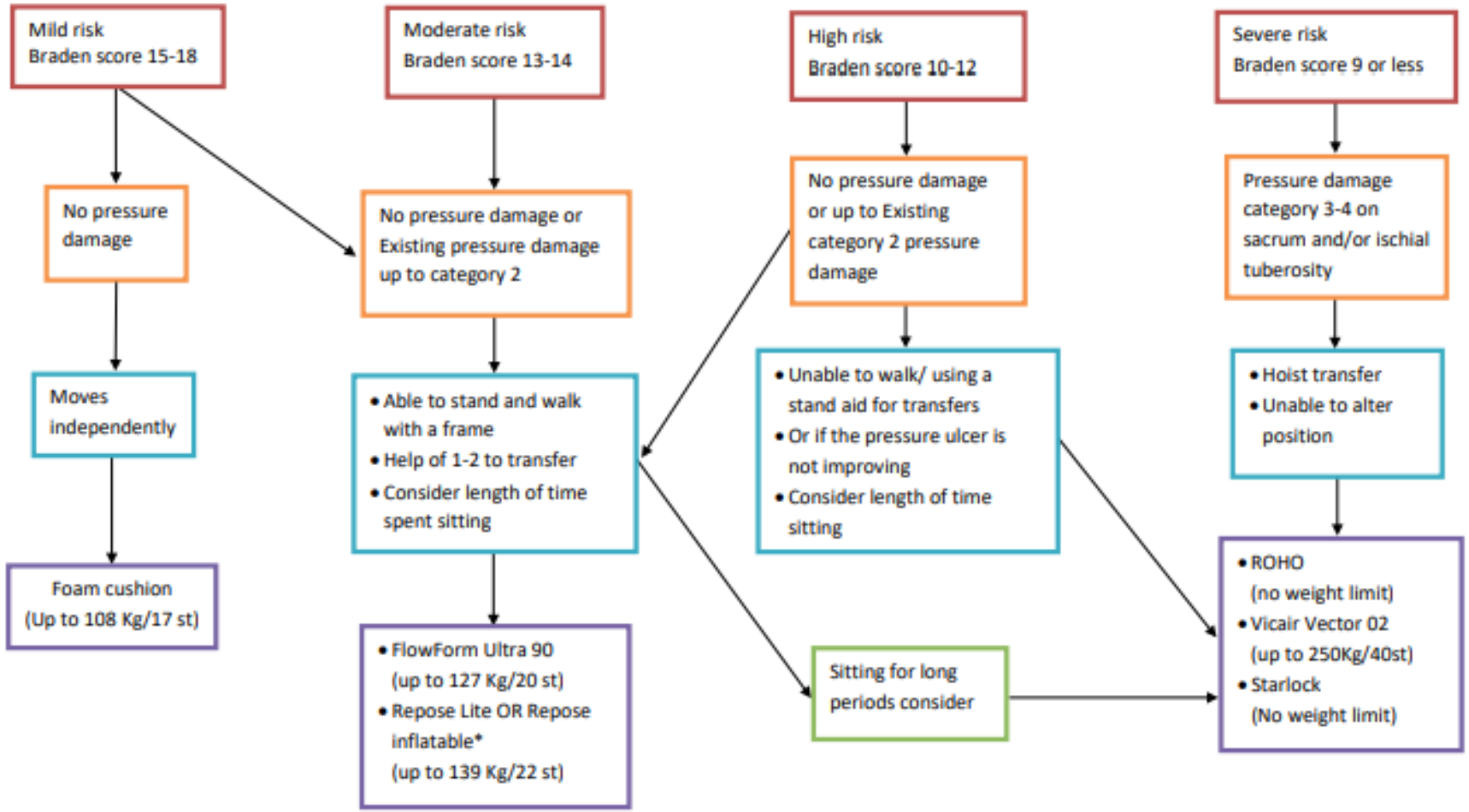

Tissue Viability/Cushion selection guide/V3/JUNE2021

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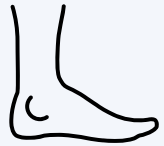
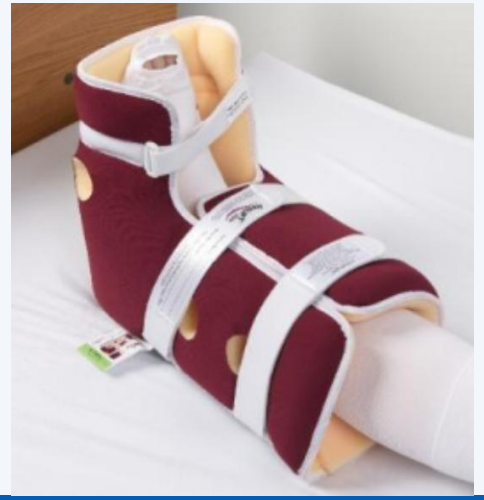
Heel Protectors:



Repose Boots (with or without magnets):

- Air filled boot with an area under the heel which totally offloads the heels.
- Middle channel reduced pressure onto the Achille's tendon.
- Not suitable for pressure damage to other aspects than the heel on the foot.
- SHOULD NOT BE PUT IN A PILLOWCASE.



Heelift Glide:

- For patiens with pressure damage to other aspects of the foot – the foam can be cut/shaped to offload.
- Extra piece of foam to manage foot drop or to prevent pronation.
- Single use.

MATTRESSES DO NOT OFFLOAD HEELS

Bespoke Equipment:

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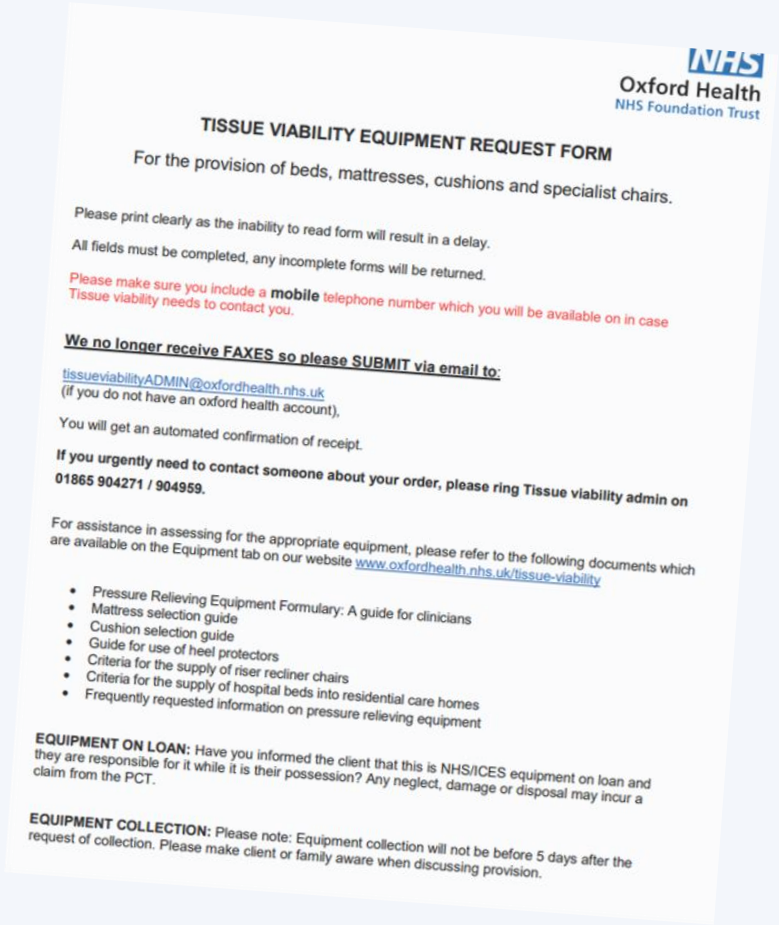
- Patients with Wheelchair Service provided wheelchairs will need referring to them for cushion support.
- Not all catalogue options will meet patient's needs.
- If patients do not concord with equipment, please refer to Tissue Viability.
- We often need to work with other professionals to meet patients' clinical needs.
- Unfortunately, although patient comfort is considered, our main goal is pressure relief and there are often other contributing factors to discomfort.

What is your responsibility as a prescriber?

- Any risk assessments to make sure it is safe for the patient,
- Checking that the equipment has arrived and is set up correctly for use,
- Advising the patient, family, carers what to look out for, especially in the event of failure,
- Any checks/re-inflation of the equipment.



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TISSUE VIABILITY EQUIPMENT REQUEST FORM

For the provision of beds, mattresses, cushions and specialist chairs.

Please print clearly as the inability to read form will result in a delay.

All fields must be completed, any incomplete forms will be returned.

Please make sure you include a **mobile** telephone number which you will be available on in case Tissue viability needs to contact you.

We no longer receive FAXES so please SUBMIT via email to:

tissueviabilityADMIN@oxfordhealth.nhs.uk
(if you do not have an oxford health account),

You will get an automated confirmation of receipt.

If you urgently need to contact someone about your order, please ring Tissue viability admin on 01865 904271 / 904959.

For assistance in assessing for the appropriate equipment, please refer to the following documents which are available on the Equipment tab on our website www.oxfordhealth.nhs.uk/tissue-viability

- Pressure Relieving Equipment Formulary: A guide for clinicians
- Mattress selection guide
- Cushion selection guide
- Guide for use of heel protectors
- Criteria for the supply of riser recliner chairs
- Criteria for the supply of hospital beds into residential care homes
- Frequently requested information on pressure relieving equipment

EQUIPMENT ON LOAN: Have you informed the client that this is NHS/ICES equipment on loan and they are responsible for it while it is their possession? Any neglect, damage or disposal may incur a claim from the PCT.

EQUIPMENT COLLECTION: Please note: Equipment collection will not be before 5 days after the request of collection. Please make client or family aware when discussing provision.

KEEP MOVING & Posture

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- Is the person able to move themselves? Do you just need to prompt them?
- Do they need mobility aids to be independent?
- Some people may have too much movement, for example, if they are fidgety, have a tremor, or are confused
- Do they need assistance? Manual handling risk assessments & aids ?MDT involvement
- If someone is immobile, try to plan repositions around the person's routine:

  when do they eat? (a good time to sit up or in a chair)

  when do they need to go to the toilet?

Consider posture – are three shearing forces?

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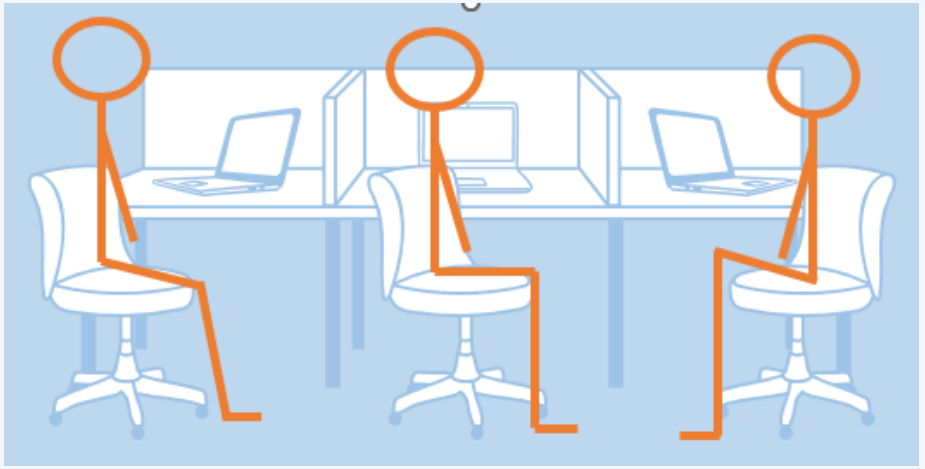
SEATED



Consider chair height

Slumped?

LYING

Unsupported limbs can result in joint problems & contractures

Repositioning

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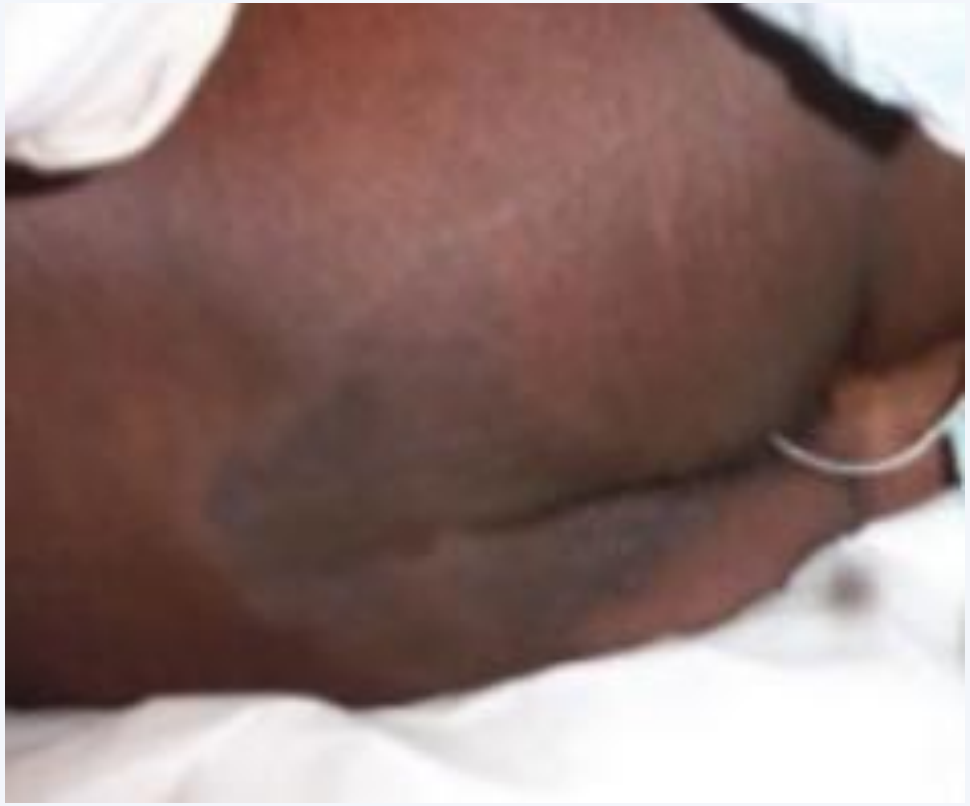
- How often? 2-3 hourly based on skin inspection. This should be an individual plan of care based on their risk level.
- What is a reposition? – micro or macro? Is the same area still taking weight eg sitting in chair to sitting in bed
- Do not reposition onto an already reddened area.
- inspect skin more frequently to identify skin changes early
- Any blanching erythema, monitor how long the skin takes to recover. Over 10 minutes and that skin is shouting for help, reduce time spent on that area of skin.
- Use pillows or other devices to ensure the person is well supported and comfortable or they will move from the position you put them in



The 30-degree tilt

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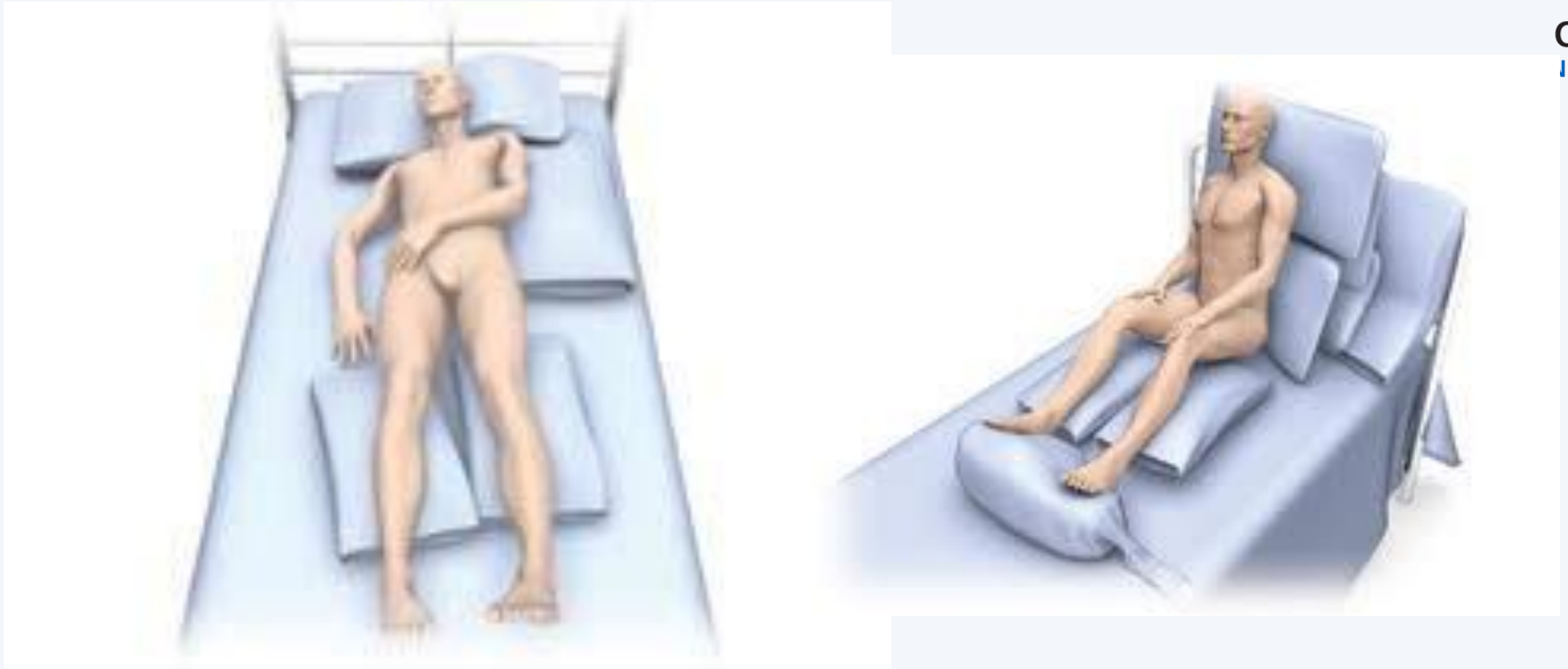
Evidence has shown the most effective position for preventing pressure ulcers is the 30-degree tilt. This is preferable in most cases to lying at 90 degrees right on the hip.

The 30-degree tilt



Leaflet on TV Website, PRESSURE Tab, Resources

Incontinence & Moisture:

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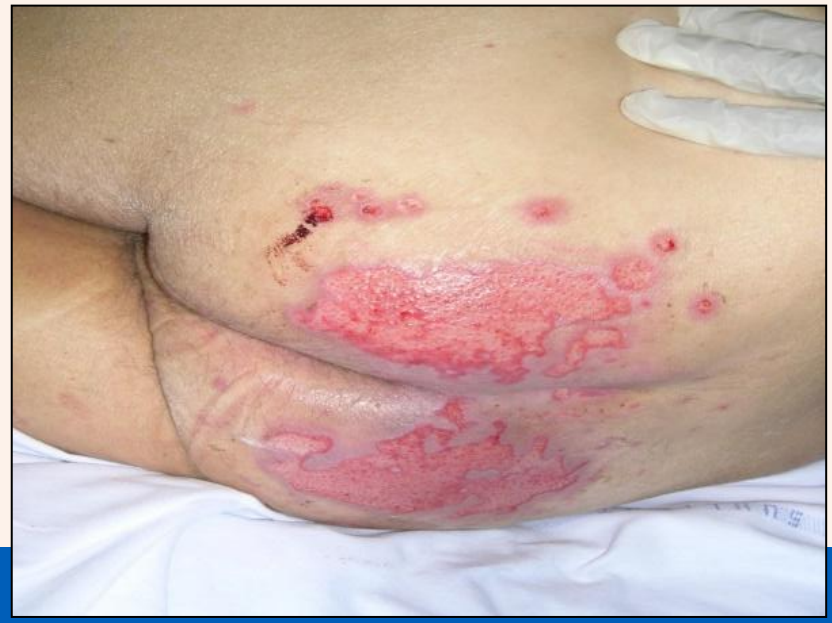
Long-term exposure of the skin to moisture is harmful and can lead to moisture-associated skin damage (MASD). It impairs the skin's barrier function increasing the risk of infection and pressure damage.

Identify the cause of moisture-related skin damage

- Is the patient incontinent?
- Does the patient have:
  - a raised temperature?
  - localised oedema
  - increased sweating?
  - leakage from a wound or stoma?
  - saliva on the skin?



Management

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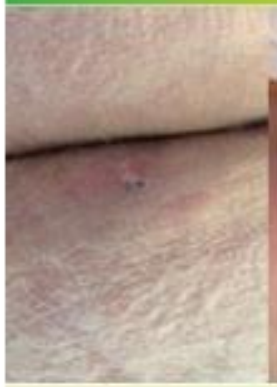
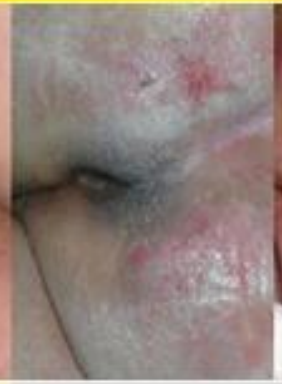
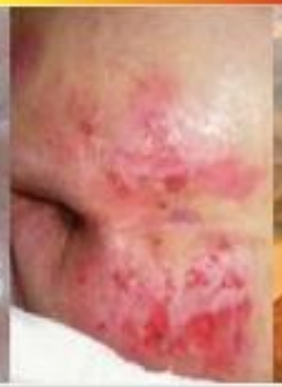
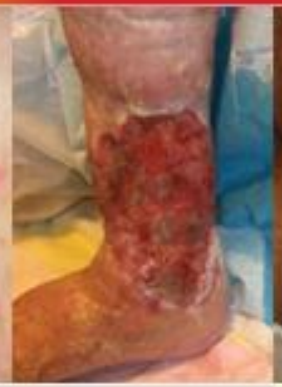
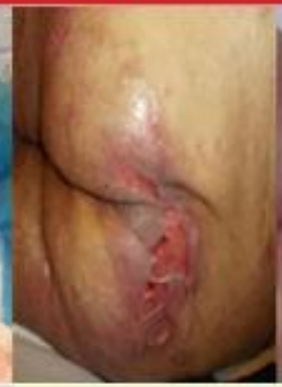
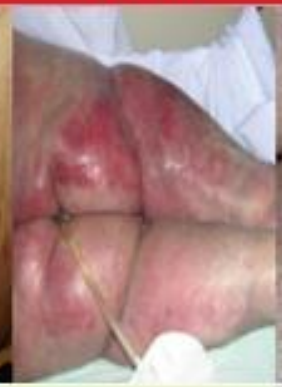
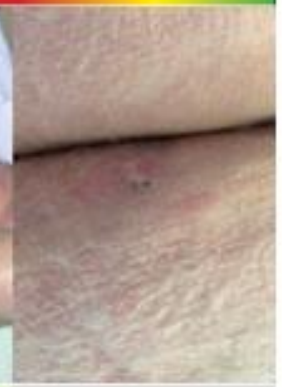
- Where possible, manage the cause of the increased fluid
- Continence assessment, refer Bladder & Bowel, Stoma Nurses
- Manage – toileting regimen, continence aids, pads, exudate management, compression bandaging
- Ensure the skin is kept clean and dry
- Skin cleansing – **NO SOAP**, emollient as a soap substitute
- Emollient to maintain skin barrier function
- Consider a barrier product

Skin Barrier Management Pathway

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS Oxford Health NHS Foundation Trust

Prevention	Skin Assessed as at Risk of IAD*	Protect & Repair			Repair	Repair	Restore
							
Optimising skin health and barrier function	At risk of moisture associated skin damage from incontinence/ perspiration	Mild skin damage from incontinence or perspiration	Moderate skin damage from incontinence	Peri-wound excoriation and/or maceration from wound exudate	Severe skin damage from incontinence. Large surface area may be affected	Moderate to severe skin damage associated with fungal or bacterial infection	Maintenanc e of restored skin integrity
↓	↓	↓	↓	↓	↓	↓	↓
Cleanse skin using an emollient as a soap substitute	Cleanse using an emollient as a soap substitute	Cleanse using an emollient as a soap substitute	Cleanse using an emollient as a soap substitute	↓	Cleanse with Medi Derma Pro Cleanser **	Cleanse using an emollient as a soap substitute	Cleanse using an emollient as a soap substitute
↓	↓	↓	↓	↓	↓	↓	↓
Apply a leave on emollient to optimise skin health	**Medi Derma-S** Barrier Cream	**Medi Derma-S** Barrier Cream	Superficial skin loss over a large surface area. Lesions maybe painful **Medi Derma-S** Film Aerosol 50ml	**Medi Derma-S** Barrier Film Sterile Applicator 1ml	**Medi Derma Pro** Skin Protectant **	**Activon Manuka Honey** Barrier Cream	Apply a leave on emollient to optimise skin health

NUTRITION

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There is a relationship between nutritional status and pressure injuries.

Underweight

- pressure damage to bony areas can be more common.

Overweight:

- the skin under and between folds can be moist, leading to skin breakdown.
- Pressure between the skin and the surface is increased in all positions by increased body weight.

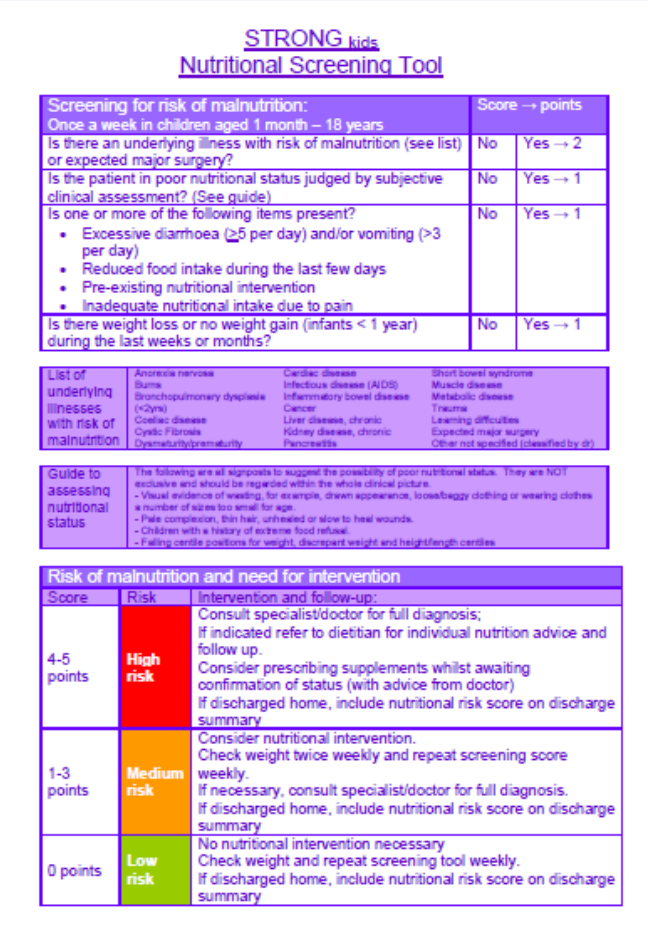
Can be misleading:

- A sudden **unplanned change in weight** is a risk factor.

Screening

It is good practice to conduct nutritional screening for individuals at risk of a pressure injury (NPIAP/EPUAP/PPPIA, 2025)

- Measure weight & BMI
- Children – BMI z-scores
- **Adults over age 18** – Malnutrition Universal Screening Tool – **M.U.S.T.**
- **Children 1 month to 18yrs** - Screening Tool for Risk on Nutritional Status and Growth – **S.T.R.O.N.G.**



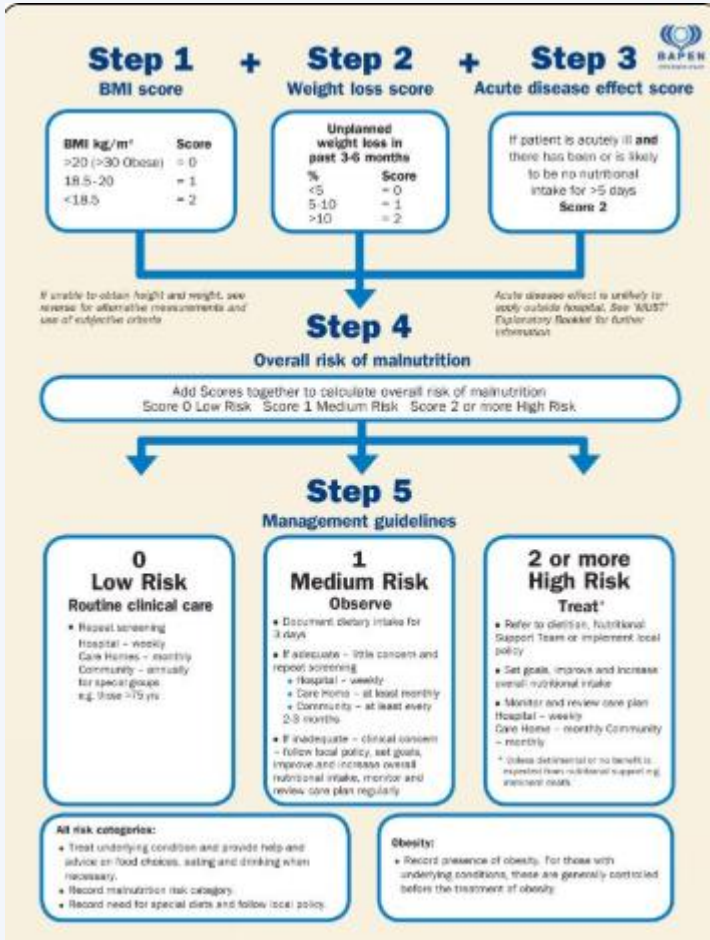
STRONG kids
Nutritional Screening Tool

Screening for risk of malnutrition: Once a week in children aged 1 month – 18 years	Score → points	
Is there an underlying illness with risk of malnutrition (see list) or expected major surgery?	No	Yes → 2
Is the patient in poor nutritional status judged by subjective clinical assessment? (See guide)	No	Yes → 1
Is one or more of the following items present? • Excessive diarrhoea (≥5 per day) and/or vomiting (>3 per day) • Reduced food intake during the last few days • Pre-existing nutritional intervention • Inadequate nutritional intake due to pain	No	Yes → 1
Is there weight loss or no weight gain (infants < 1 year) during the last weeks or months?	No	Yes → 1

List of underlying illnesses with risk of malnutrition			
	Anorexia nervosa	Cardiac disease	Short bowel syndrome
	Burns	Infectious disease (AIDS)	Muscle disease
	Bronchopulmonary dysplasia (<2yrs)	Inflammatory bowel disease	Metabolic disease
	Coeliac disease	Cancer	Trauma
	Cystic Fibrosis	Liver disease, chronic	Learning difficulties
	Dysmaturity/prematurity	Kidney disease, chronic	Expected major surgery
		Pancreatitis	Other not specified (classified by dr)

Guide to assessing nutritional status	The following are all signposts to suggest the possibility of poor nutritional status. They are NOT exclusive and should be regarded within the whole clinical picture. - Visual evidence of wasting, for example, drawn appearance, loose/baggy clothing or wearing clothes a number of sizes too small for age. - Pale complexion, thin hair, unhealed or slow to heal wounds. - Children with a history of extreme food refusal. - Falling centile positions for weight, discrepant weight and height/length centiles

Risk of malnutrition and need for intervention		
Score	Risk	Intervention and follow-up:
4-5 points	High risk	Consult specialist/doctor for full diagnosis; If indicated refer to dietitian for individual nutrition advice and follow up. Consider prescribing supplements whilst awaiting confirmation of status (with advice from doctor) If discharged home, include nutritional risk score on discharge summary
1-3 points	Medium risk	Consider nutritional intervention. Check weight twice weekly and repeat screening score weekly. If necessary, consult specialist/doctor for full diagnosis. If discharged home, include nutritional risk score on discharge summary
0 points	Low risk	No nutritional intervention necessary Check weight and repeat screening tool weekly. If discharged home, include nutritional risk score on discharge summary



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FURTHER ASSESSMENT

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- Can the person reach the food or drink?
- Can they hold and manipulate it?
- Are they able to chew effectively without pain or denture movement?
- Are they able to maintain good oral hygiene?
- Do they have any problems with swallowing?
- Mental health & cognition?
- Personal, family, cultural, ethnic & religious dietary practices and preferences
- socio-economic factors or other factors which may be impacting their ability to have a balanced diet.

Onward referral:

- **OT** - can support clients who have difficulties with the physical act of eating.
- **Speech & Language Therapist** - those who are at risk or who have dysphagia
- **Dietician**

NUTRITION

1. **Calories** – pressure ulcers increase your calorie needs.
2. **Protein** – needed to make and repair tissue.
3. **Water** – for transportation of nutrients and to get rid of waste products.
4. **Vitamins & minerals**

A balanced diet – The Eatwell Guide – age 2 & up

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You should ask the person about their diet and, where necessary, advise the person about the need for a balanced diet

Food First: Advice for eating if you have lost weight or are underweight

You may have been given this resource because you have lost weight, are at risk of weight loss or are trying to gain weight. If you have swallowing difficulties, specific dietary requirements or have diabetes, this resource may not be appropriate for you. Please speak to a Dietitian for personalised advice.

What do I need to do to prevent further weight loss and promote weight gain?

① Aim to have 1 pint of full fat (whole milk) each day (see below) and,

② Include 2 high energy snacks each day from the list below and,

③ Aim to eat 3 meals a day that have been fortified (see below)

It is recommended to **aim for an additional 500 calories (energy) per day to support weight gain.** Ideally this should include high protein foods to help prevent muscle loss and restore lost muscle.

PROTEIN

Implement protein supplementation for individuals at risk of pressure injury who have been identified as malnourished or at risk of malnourishment.

Children – refer to dietician

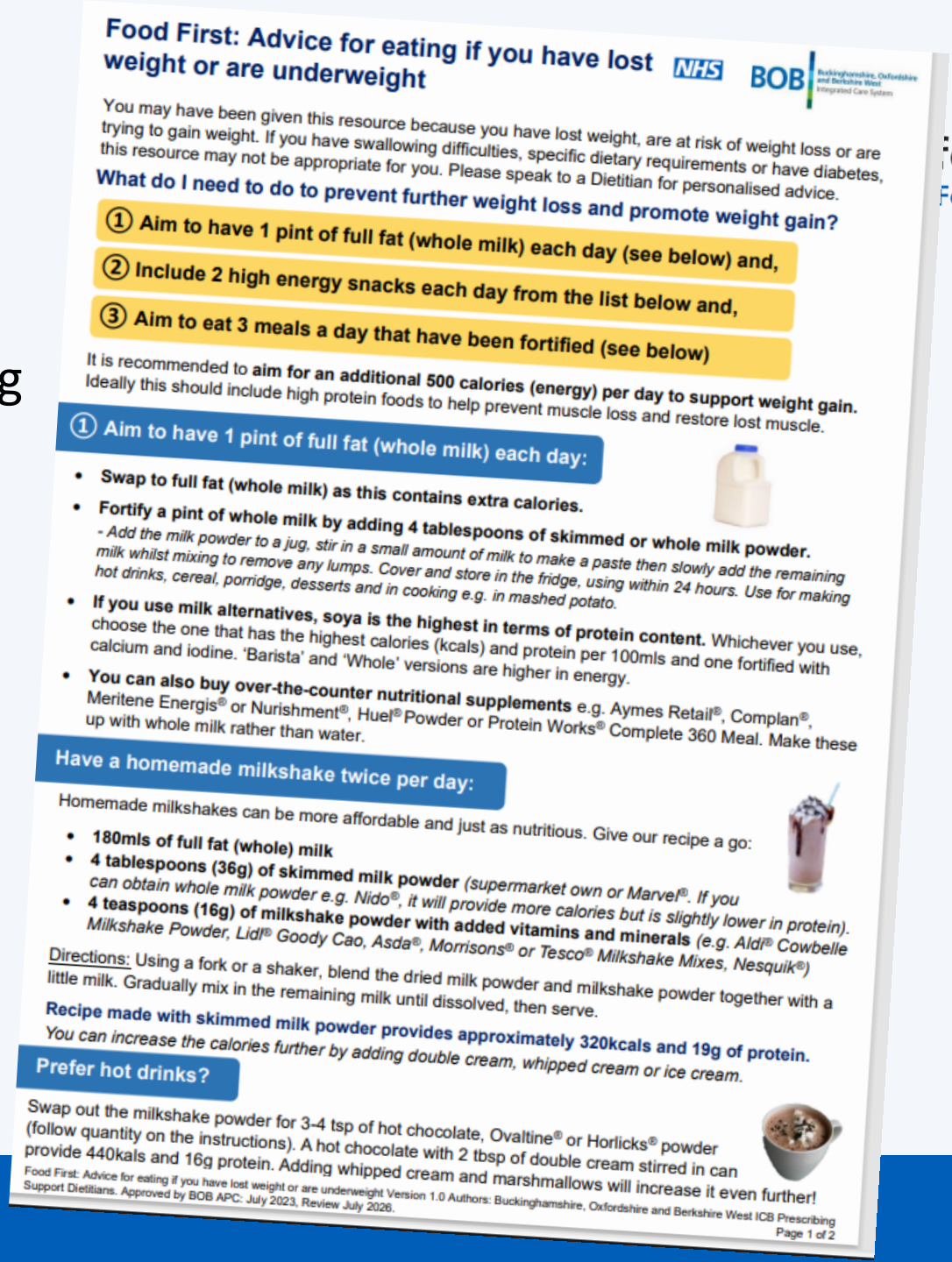
Older adults – 1.2-1.5 g protein per Kg body weight

Critically Ill or obesity – 2g/kg

Food Fortification:

The easiest way to increase protein intake and calories is through fortifying milk with milk powder:

- 1 pint of whole milk + 4 tablespoons of milk powder = lots of calories and protein.
- This can be used in drinks, porridge, soup, milkshakes, mash, etc.



Food First: Advice for eating if you have lost weight or are underweight

NHS BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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It is recommended to **aim for an additional 500 calories (energy) per day to support weight gain.** Ideally this should include high protein foods to help prevent muscle loss and restore lost muscle.

① Aim to have 1 pint of full fat (whole milk) each day:

- **Swap to full fat (whole milk) as this contains extra calories.**
- **Fortify a pint of whole milk by adding 4 tablespoons of skimmed or whole milk powder.** *- Add the milk powder to a jug, stir in a small amount of milk to make a paste then slowly add the remaining milk whilst mixing to remove any lumps. Cover and store in the fridge, using within 24 hours. Use for making hot drinks, cereal, porridge, desserts and in cooking e.g. in mashed potato.*
- **If you use milk alternatives, soya is the highest in terms of protein content.** Whichever you use, choose the one that has the highest calories (kcals) and protein per 100mls and one fortified with calcium and iodine. 'Barista' and 'Whole' versions are higher in energy.
- **You can also buy over-the-counter nutritional supplements** e.g. Aymes Retail®, Complan®, Meritene Energis® or Nurishment®, Huel® Powder or Protein Works® Complete 360 Meal. Make these up with whole milk rather than water.

Have a homemade milkshake twice per day:

Homemade milkshakes can be more affordable and just as nutritious. Give our recipe a go:

- **180mls of full fat (whole) milk**
- **4 tablespoons (36g) of skimmed milk powder** *(supermarket own or Marvel®. If you can obtain whole milk powder e.g. Nido®, it will provide more calories but is slightly lower in protein).*
- **4 teaspoons (16g) of milkshake powder with added vitamins and minerals** *(e.g. Aldi® Cowbelle Milkshake Powder, Lidl® Goody Cao, Asda®, Morrisons® or Tesco® Milkshake Mixes, Nesquik®)*

Directions: Using a fork or a shaker, blend the dried milk powder and milkshake powder together with a little milk. Gradually mix in the remaining milk until dissolved, then serve.

Recipe made with skimmed milk powder provides approximately 320kcals and 19g of protein. *You can increase the calories further by adding double cream, whipped cream or ice cream.*

Prefer hot drinks?

Swap out the milkshake powder for 3-4 tsp of hot chocolate, Ovaltine® or Horlicks® powder (follow quantity on the instructions). A hot chocolate with 2 tbsp of double cream stirred in can provide 440kals and 16g protein. Adding whipped cream and marshmallows will increase it even further!

Food First: Advice for eating if you have lost weight or are underweight Version 1.0 Authors: Buckinghamshire, Oxfordshire and Berkshire West ICB Prescribing Support Dietitians. Approved by BOB APC: July 2023, Review July 2026.

Page 1 of 2

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Hydration

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Water makes up two-thirds of our body.

Needed to transport vitamins, minerals and nutrients through the body, and to eliminate waste products.

Dehydration can cause the skin to be dry, impair the barrier function and put us at higher risk of pressure damage.

In healthy individuals, water/fluid intake should be approximately 30 ml/Kg of body weight/day.

Caution: fluid restrictions? Diarrhoea, vomiting, temperature, sweating, high exudate levels from wounds

Giving Information

- To the patient
- Their carer/family
- Keep information clear and simple and ensure the person knows who to contact if they notice any changes in their pressure areas.

What information?

- Outcome of PURPOSE-T – 'at risk'
- Reasons why at risk – what yellow, amber or red boxes did you tick?
- Discuss and agree proposed management plan for those risk factors
- Leaflets – PU, Equipment, on TV Website

Giving information

T

Documentation is key

Do I need to escalate?

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- Deterioration? Refer to Tissue Viability
- Pressure ulcer not healed in 12 weeks – refer to tissue viability
- GP? Pressure ulcers don't need antibiotics unless showing signs of spreading or systemic infection (consider exposed structures)
- Cat 3 or 4 – sepsis risk – monitor
- Exposed bone – risk of osteomyelitis
- Plastics? Follow OUH guidance – Link in policy

- Policy Go Live 1st April – stop Braden & start PURPOSE-T – ALL PATIENTS!
- This session will be recorded & on L&D site for those unable to attend
- Ongoing training on staff matrices after 1st April

Before I forget - Evaluation

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