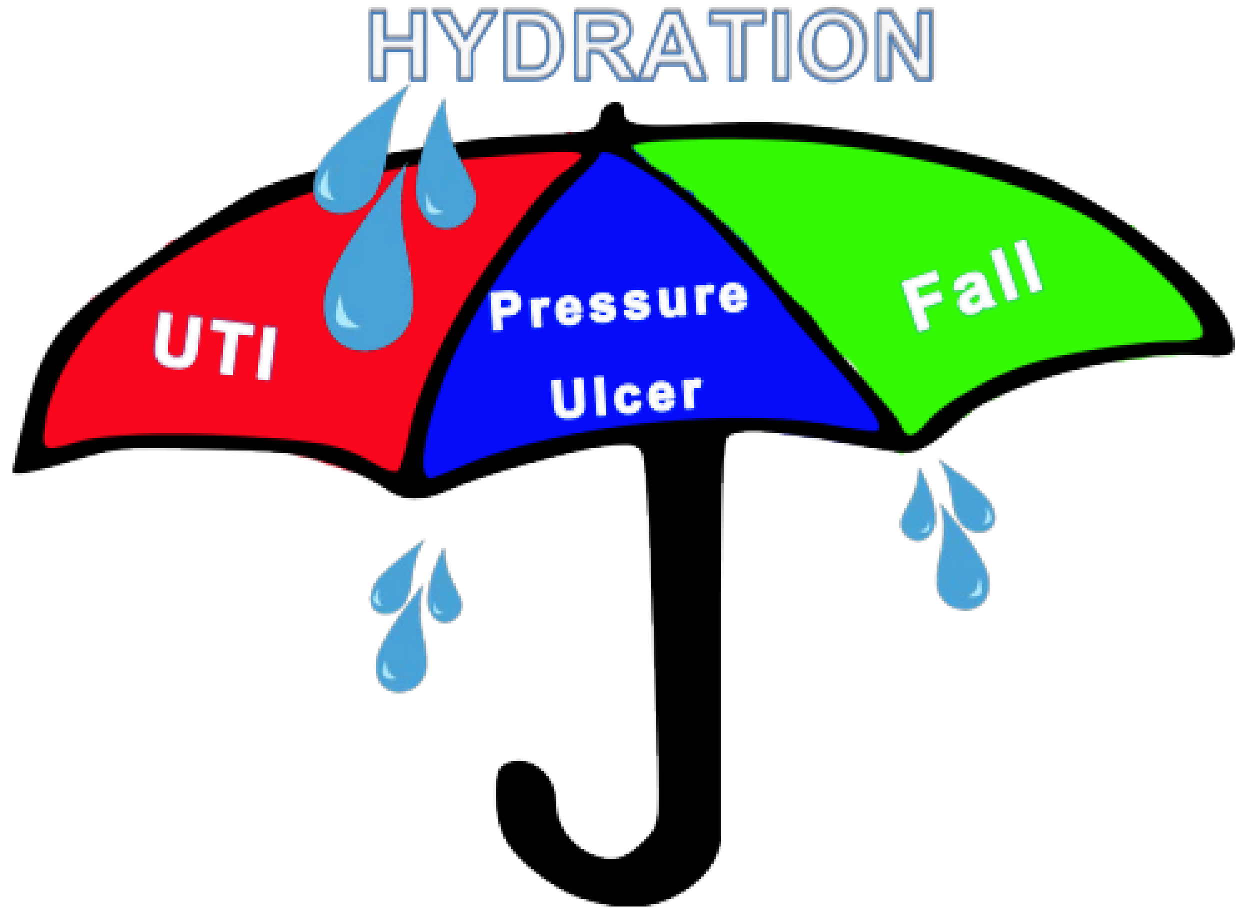


Getting Hydration correct…….. Could see a reduction in the above 3 areas.

Remember HYDRATION IS KEY!

Implementation

- Prosper Champions
- Safety Cross
- Falls checklists
- Medication Reviews
- Good Slipper guides at pre-assessment
- On spot debriefs
- SBAR

Focus on Hydration

- Doily's
- Hydration stations
- Training for staff/residents/relatives
- Fluid content of foods
- Involving Chefs
- Fluid intake monitoring on admission

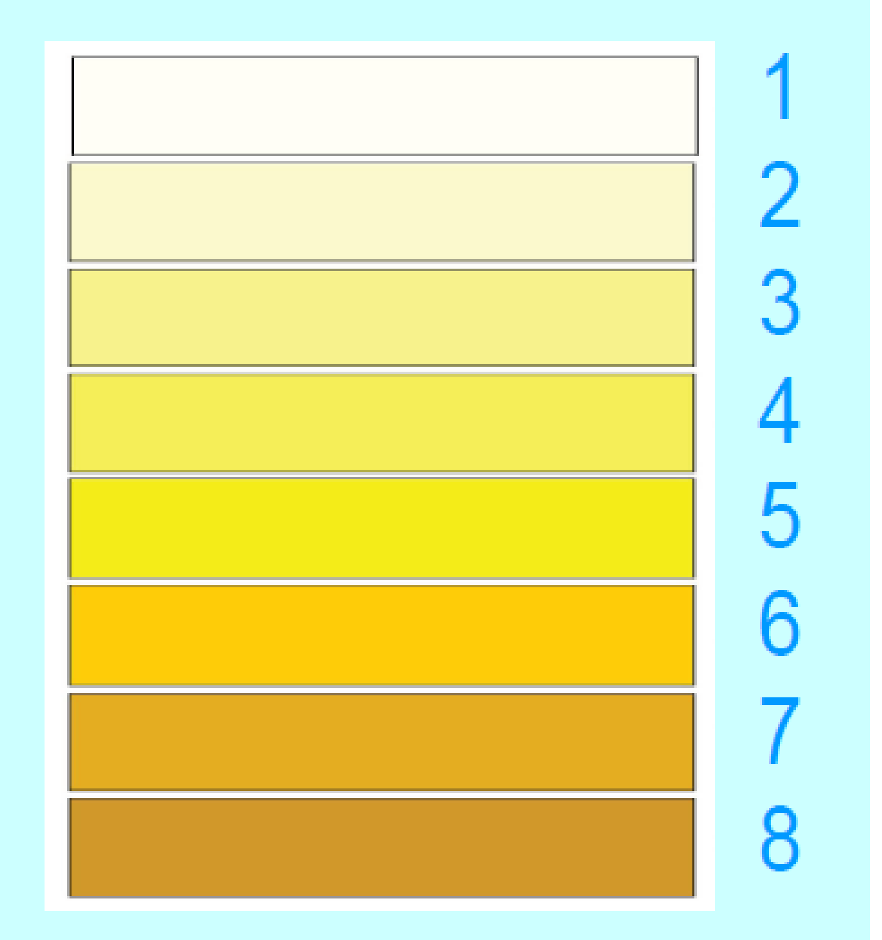
Jelly!

Average volumes of fluids from foods

Healthy pee is 1 – 3…….4 - 8 REHYDRATE

You should aim to drink approx 8 glasses or mugs (1.6-2 litres or 3-4 pints) of fluid each day to keep you hydrated. Signs that you are not drinking enough can include: ***thirst, a dry mouth, tiredness , headache, dry loose skin, constipation, and dark coloured or strong smelling urine*.**

Use the urine colour chart to check for signs of dehydration



Falls

TUMBLES

Toilet

Urine

Medication and mobility

Beds, bells and blood pressure

Lighting

Eyesight and exercise

Slippers and shoes

SSKIN BUNDLE

95% of pressure ulcers are completely avoidable if we follow the SSKIN bundle

Remember:

Surface (mattress presures, support etc)

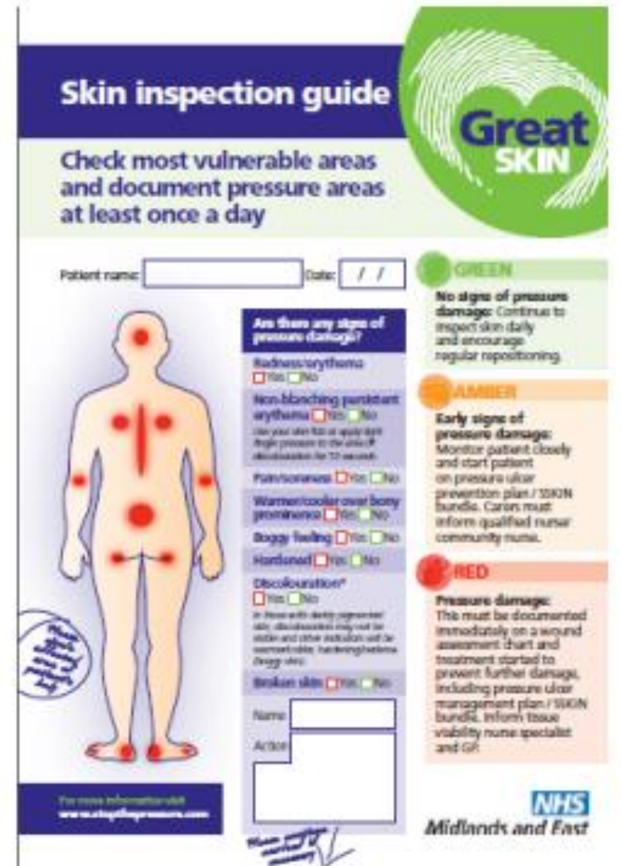
Skin inspection

Keep moving

Incontinence (keep patients clean and dry)

Nutrition.

Pressure Ulcers



What does this mean for you ?

If you are a registered nurse

✓ Ensure that all patients ‘at risk’ and who need assistance to mobilise have an appropriate repositioning plan

✓ Ensure that there is are clear criteria for repositioning frequency

✓ Ensure that repositioning frequency is communicated at handover including time of last reposition

✓ Ensure that changes in skin condition are documented and acted upon

✓ Ensure that waterlow & MUST scores are completed monthly or change in condition and **act on the results!**

If you are a carer

Think SSKIN

Surface (mattress, support etc)

Skin inspection

Keep moving ✓ Ensure that you know how frequently patient need to be repositioned

Incontinence (keep patients clean and dry)

Nutrition.

✓ **REACT to RED**

REACT TO RED SKIN
STOP
PRESSURE
ULCERS

Moisture lesions vs pressure ulcers

Differentiation between pressure ulcers and moisture lesions

Location	Moisture lesions	A combination of moisture and friction may cause moisture lesions in skin folds, but most commonly they are present in the anal cleft.
	Pressure ulcers	A pressure ulcer is most likely to occur over a bony prominence.
Necrosis	Moisture lesions	There is no necrosis in a moisture lesion.
	Pressure ulcers	A black necrotic scab on a bony prominence is a pressure ulcer classification 3 or 4.
Shape	Moisture lesions	Diffuse, different superficial spots are more likely to be moisture lesions. In a kissing ulcer (copy lesion) at least one of the wounds is most likely caused by moisture.
	Pressure ulcers	Circular wounds or wounds with a regular shape are most likely pressure ulcers, however, the possibility of friction injury has to be excluded.
Edges	Moisture lesions	Moisture lesions often have diffuse or irregular edges.
	Pressure ulcers	If the edges are distinct, the lesion is most likely to be a pressure ulcer.
Depth	Moisture lesions	Moisture lesions are superficial (partial thickness skin loss). In cases where the moisture lesion gets infected, the depth and extent of the lesion can be enlarged.
	Pressure ulcers	Pressure ulcers vary in depth depending on classification.
Colour	Moisture lesions	If redness is not uniformly distributed, the lesions is likely to be a moisture lesion.
	Pressure ulcers	If redness is non-blanchable, this is most likely a pressure ulcer. For people with darkly pigmented skin, persistent redness may manifest as blue or purple.