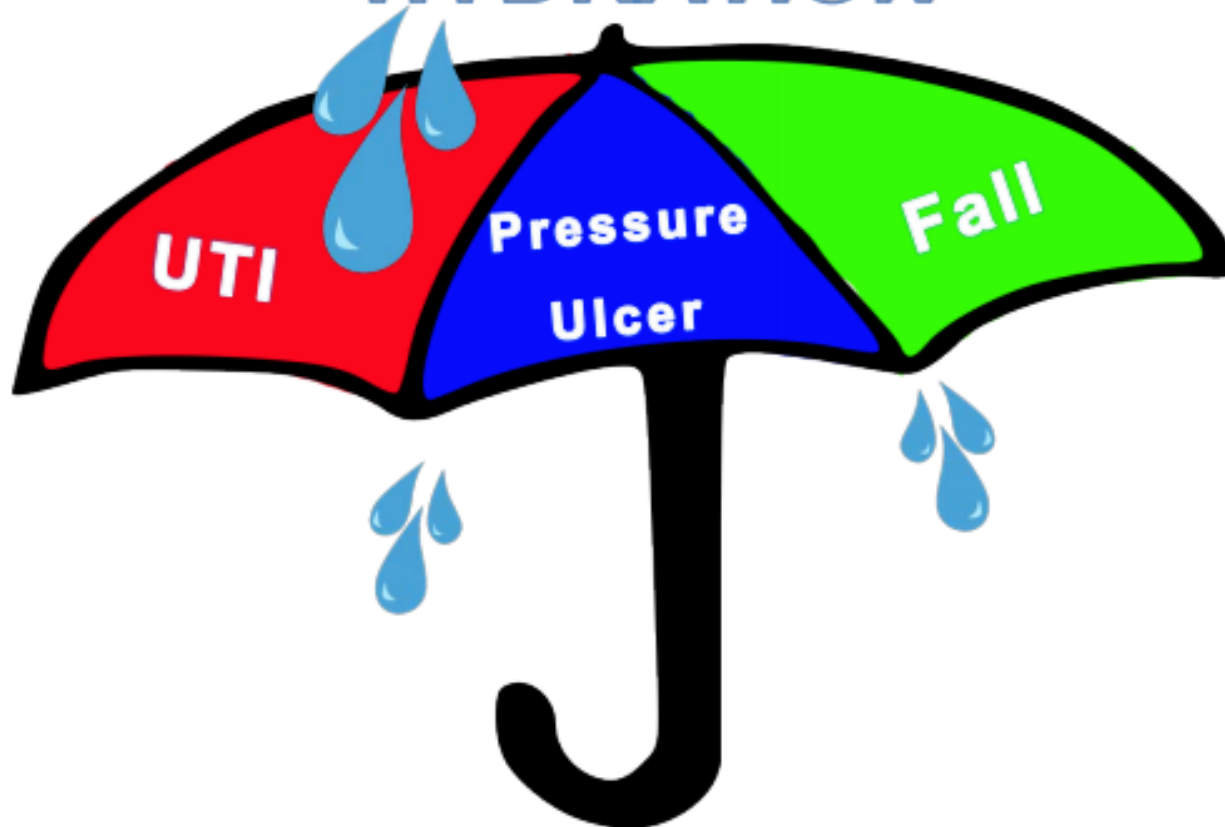


HYDRATION



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



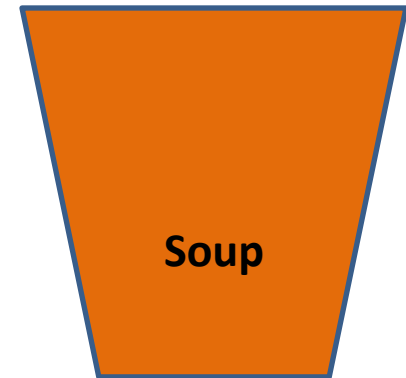
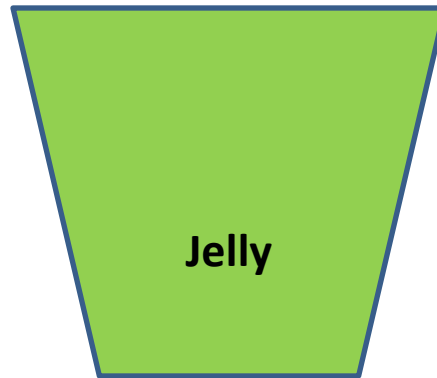
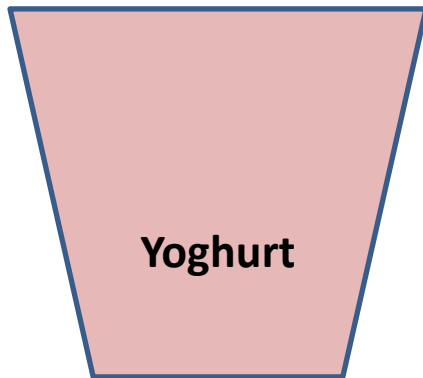
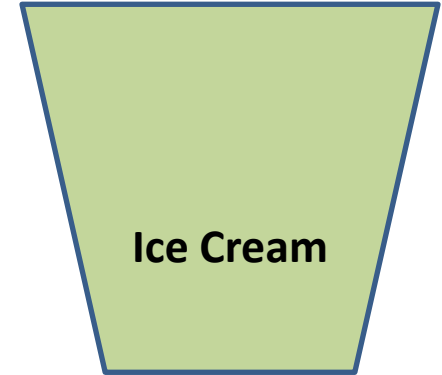
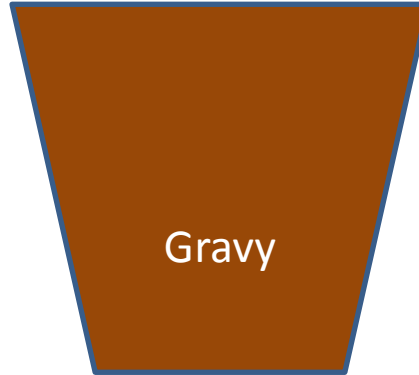
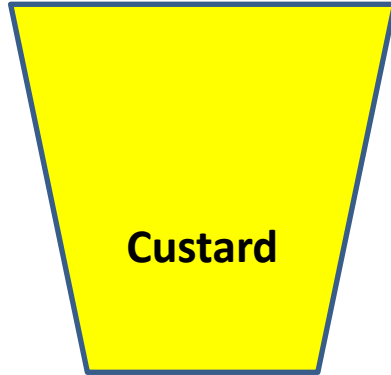
- Doily's
- Hydration stations
- Training for staff/residents/relatives
- Fluid content of foods
- Involving Chefs
- Fluid intake monitoring on admission



Jelly!



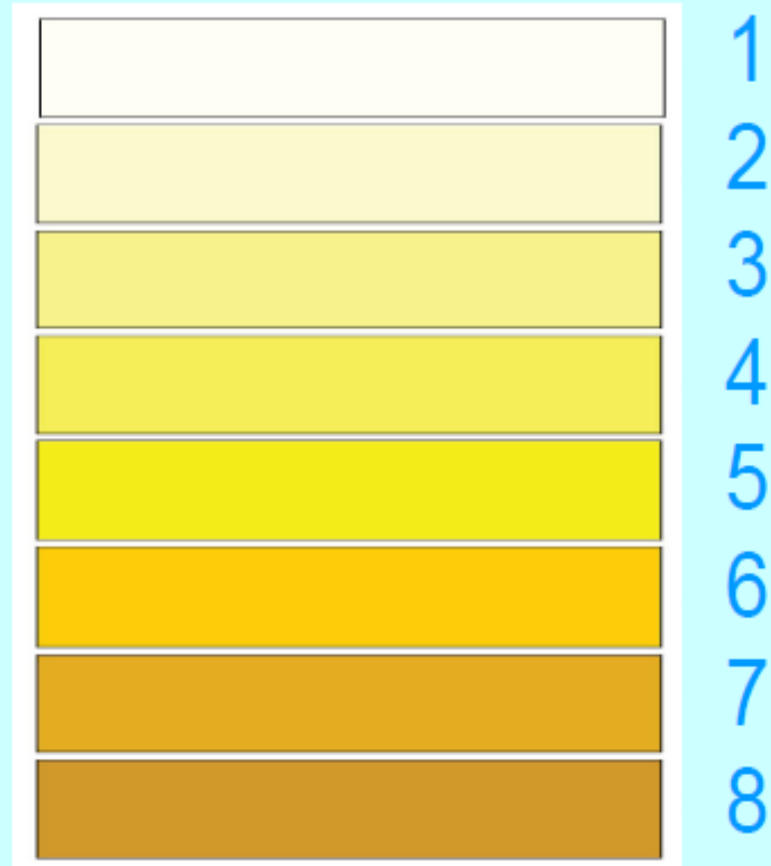
Average volumes of fluids from foods



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

The 7 steps falls prevention checklist
patient information booklet



NHS

Essex County Council



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 pressures, support etc)

Skin inspection

Keep moving


Incontinence (keep patients clean and dry)

Nutrition.




Pressure Ulcers

Skin inspection guide



Check most vulnerable areas and document pressure areas at least once a day

Patient name: Date: / /



Are there any signs of pressure damage?

Redness/erythema Yes No

Non-blanching persistent erythema Yes No
Use your skin test as guide. Don't apply pressure to the skin. If discoloured for 10 seconds.

Pain/tenderness Yes No

Warmer/cooler over bony prominences Yes No

Itchy feeling Yes No

Hardened Yes No

Discolouration* Yes No
*In line with daily regimen skin discolouration may not be visible and other patients will be susceptible. Pain/erythema (dry skin)

Broken skin Yes No

Name:

Action:

When using the assessment

GREEN


No signs of pressure damage: Continue to inspect skin daily and encourage regular repositioning.

AMBER

Early signs of pressure damage: Monitor patient closely and start patient on pressure ulcer prevention plan / SKIN bundle. Carers must inform qualified nurse community nurse.

RED

Pressure damage: This must be documented immediately on a wound assessment chart and treatment started to prevent further damage, including pressure ulcer management plan / SKIN bundle. Inform tissue viability nurse specialist and GP.



For more information visit www.nhs.uk/england/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**



Moisture lesions vs pressure ulcers

Differentiation between pressure ulcers and moisture lesions

Location		<p>Moisture lesions</p> <p>Pressure ulcers</p>	<p>A combination of moisture and friction may cause moisture lesions in skin folds, but most commonly they are present in the anal cleft.</p> <p>A pressure ulcer is most likely to occur over a bony prominence.</p>
Necrosis		<p>Moisture lesions</p> <p>Pressure ulcers</p>	<p>There is no necrosis in a moisture lesion.</p> <p>A black necrotic scab on a bony prominence is a pressure ulcer classification 3 or 4.</p>
Shape		<p>Moisture lesions</p> <p>Pressure ulcers</p>	<p>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.</p> <p>Circular wounds or wounds with a regular shape are most likely pressure ulcers, however, the possibility of friction injury has to be excluded.</p>
Edges		<p>Moisture lesions</p> <p>Pressure ulcers</p>	<p>Moisture lesions often have diffuse or irregular edges.</p> <p>If the edges are distinct, the lesion is most likely to be a pressure ulcer.</p>
Depth		<p>Moisture lesions</p> <p>Pressure ulcers</p>	<p>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.</p> <p>Pressure ulcers vary in depth depending on classification.</p>
Colour		<p>Moisture lesions</p> <p>Pressure ulcers</p>	<p>If redness is not uniformly distributed, the lesions is likely to be a moisture lesion.</p> <p>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.</p>