Medical Conditions

- Does the person have any medical conditions which increase the risk of a pressure sore developing such as diabetes, stroke, dementia, Parkinson's Disease, etc
- How has their medical condition affected them? i.e. bedbound, retracted limbs or hands, incontinent, decreased senses, decreased mobility, unable to eat/drink
- Is any medication they are taking increasing a risk of developing a pressure sore? i.e. steroids,
- What are the high risk areas for them? BESTSHOT
- What do they need support with to maintain their skin integrity? i.e. nutrition, pain relief, a suitable surface etc

Assessments

Have you completed the following?

- Waterlow
- MUST
- Wound Assessment Tool
- Skin Risk Assessment
- Body Map
- Mobility Assessment

Assessments

Does the service user need any of the following?

- Food & Fluid Chart
- Repositioning Chart
- Skin Tolerance Test
- Bed Rail Assessment
- Weekly/Monthly Weights
- Incontinence Assessment

Prevention

S - Surface. What surfaces do the service user needed? i.e. airwave mattress, Repose Boots, Aderma Pad

S - Skin. What skin care does the person need?
i.e. moisturiser cream, 4 hourly personal hygiene

K - Kinesthetic. What movement does the person need?
i.e. chair exercises, passive movements, Baclofen

I - Incontinence. What support does the person need?
i.e. how often is the support, how many staff, size of aid

N - Nutrition. What support does the person need?
i.e. supplements, puree diet, full support of one person

Referrals

Who could we contact to help support the service user?

- Tissue Viability
- District Nurse
- Dietitian
- Physiotherapist
- Occupational Therapist
- G.P
- Continence Nurse
- Specialist Nurse i.e. Diabetic nurse if their blood sugar levels are not controlled, this could prevent the healing process or increase the risk of skin breakdown.

BESTSHOT

(Areas prone to developing pressure sores)

B - Buttocks

E - Elbows/ Ears

S - Sacrum

T - Trochaners (hips)

S - Spine/Shoulders

H - Heels

O - Occipital Area (Back of the head)

T - Toes/ Ankles

What To Look For

1. Redness - non blanching when doing the Skin Tolerance Test
2. Pain or discomfort
3. Hardened skin
4. Discolouration
5. Broken or cracked/split skin
6. Bleeding
7. Malodor
8. Maceration - wet skin

What Effects Your Skin

- **Stress** - whether caused by a lack of sleep, pain, social isolation, it can harm your skin
- **Diet** - a high carbohydrate diet can lead to skin damage & increase the risk of diabetes. Our skin needs protein, fats minerals (calcium, zinc, magnesium) & vitamins (A, C, D & E) to remain healthy.
- **Hydration** - our skins loves to be well hydrated.
- **Exercise** - this increases and helps maintain blood flow, happiness and pressure relief.
- **Smoking** - damages our skin among many other organs.
- **Creams** - to manage Eczema, Psoriasis, dry skin or act as a protective barrier.
- **Infections** - these can accelerate skin breakdown.
- **Wet Environments** - increases the risk of skin breakdown through maceration.
- **Sleep** - a good nights sleep increases healing.

Chris's Condition

Chris has had a stroke which has affected his ability to self care. In order to help support Chris minimise the risk of developing a pressure sore, staff should ask Chris if they can support him on every intervention. Chris is understanding of his support needs and consents verbally and non-verbally.

The stroke Chris experienced has resulted in a weakness in his left arm and left leg due to hemiplegia. Chris has lost the sensation to feel pressure or pain which increases his risk at developing a pressure sore as Chris is unable to alert staff or reposition himself. Chris's left hand has started to become contracted which has increased the risk of developing a moisture lesion, especially during the summer months as he is more likely to sweat into his hand. Chris is left handed and currently finds it more difficult to assist himself with nutrition and hydration. This can increase the risk of pressure sores forming, but also the risk of delayed healing due to a reduction in hydration and nutrition if Chris isn't supported. Due the stroke, Chris has become doubly incontinent which has increased his risk of moisture lesions and pressure sores. If Chris was to develop a moisture lesion/pressure sore in his groin or sacral area, the wound will be at a high risk of becoming infected. As Chris's stroke has damaged his nerves, Chris is no longer able to sense if he has had an episode of incontinence.

Due to Chris's difficulties moving his left arm, he is currently unable to apply any barrier cream to his most vulnerable pressure areas, these are his left shoulder, elbow and hand, left hip, knee, heel and toes, his sacral area and buttocks. Chris requires support with ensuring his airwave mattress is inflated to his weight in KG, ensuring the mattress and bed are in good working order and operational. Chris also requires support to manage his stock of toiletries, barrier creams and incontinence aids. Chris currently needs support with all his meals and snacks but is able to manage a drink if its provided to him in a beaker with a lid; see Nutritional care plan for more details.

Support Plan

Once a month Chris's chosen key worker, Michelle, should review this care plan with him and repeat his Waterlow assessment for his risk of developing a pressure sore. Michelle should review Chris's Bed Rail Assessment once a month to ensure he is safe to using bed rails. Chris's MUST tool should be reviewed monthly along with his weight to monitor if Chris is receiving enough nutrition and Chris's airwave mattress is set to his current weight. Chris currently doesn't have a pressure sore, however he has experienced them in the past and is at a very high risk; his Waterlow score is 21. His G.P has prescribed prophylactic wound dressings for when Chris develops another pressure sore; these are labelled and in the wound dressing cupboard in the stock room. Chris also has prophylactic antibiotics in the medication cupboard in the medication room, in case his wound becomes infected. Chris is prone to developing pressure sores in his sacral area. If this occurs, the nurse on shift should complete a body map and a wound assessment and update Chris's skin integrity care plan and risk assessment. Chris may require a catheter for a short period of time if he develops a moisture lesion or pressure sore around this groin, sacrum or buttocks. Once a month Michelle should assess Chris's mobility to see if he requires additional support and how this is affecting his ability to maintain his own pressure areas.

Chris is currently nursed on an airwave mattress set to his weight in KG which is currently 95kg. He has a Repose Boot in place on his left foot as his left heel is at risk of becoming damaged. Chris uses a hand splint or sometimes an Aderma pad to help relieve any pressure caused by his retracted left hand. Chris has been prescribed Baclofen for his hand to help reduce the tightness in his retraction. Chris has been prescribed Cavilon Cream to apply to his most vulnerable areas: his left shoulder, elbow and hand, left hip, knee, heel and toe, his sacral area and buttocks. Staff should ensure Chris's skin is clean and dry prior to applying this cream. Chris's skin should be cleaned and dried after episodes of incontinence and a new layer of Cavilon Cream applied. Chris currently uses a medium sized slip pad from Tena which should be checked every 4 hours by two member of staff. Chris has consented to support every 4 hours to be repositioned and supported with personal hygiene if required. Chris requires two members of staff to use his large sized slide sheet, which is located in

his wardrobe, to assist him with repositioning. Staff should check Chris's skin integrity on each occasion, especially his most vulnerable areas. Staff should ask Chris for consent to preform the Skin Tolerance Test where staff use a finger to gently pressed on Chris's skin for 10-15 seconds to see if it blanches or not. This indicates the starting of a pressure sore developing, grade 1, if the area doesn't blanch and remains red. If staff are concerned that a pressure sore maybe developing, they should inform the nurse on shift and ask Chris if he would consent to being repositioned every 2 hours instead. Chris should not be repositioned onto his left hand-side as he is unable to feel pain or sense if his skin is becoming damaged. When assisting Chris with his repositioning, staff should ask Chris if he would like support with some passive movements on his left arm and left leg; see Mobility care plan for more detail on Chris's prescribed passive movements. Chris has been referred to the dietitian to ensure he is receiving enough nutrition to help prevent a pressure sore from occurring. The dietitian Melissa has prescribed Chris with forticreme once a day. Chris currently requires full support with his nutrition to ensure he is able to manage his meals and snacks. Staff should monitor Chris's nutritional and fluid intake on his Food and Fluid Chart to ensure he is having enough everyday.

Referrals

Chris's G.P is aware of his risk of developing a pressure sore or moisture lesion and has prescribed prophylactic Aquacel and Allevyn Gentle Board 10cmx10cm dressings. These are labelled and in the wound dressing cupboard in the stock room. Chris's G.P has also prescribed prophylactic antibiotics, Amoxicillin, in case Chris's wound becomes infected again. Chris currently doesn't require the support of the district nurses or tissue viability but they can be contacted via the following numbers: District Nurses 0116 481 0323 and Tissue Viability 0116 481 0323 if staff discover Chris has a pressure sore. Chris has the physiotherapist Mel coming in once a month to monitor Chris's movement and mobility. Chris has been prescribed passive movements which are detailed in his Mobility care plan.