

The SSKIN Bundle

A Reference Guide For Community Health Care Teams

To be used in conjunction with the Isle of Wight NHS Trust Policy for the Prevention of Pressure Ulcers

SSKIN
SURFACE
KEEP MOVING
INCONTINENCE
NUTRITION & HYDRATION

Useful links

www.stopthepressure.com/sskin
www.stopthepressure.com/path
www.npuap.org/Pressure
www.epuap.org

<http://intranet/guidelines/Pressure%20Ulcer%20Prevention%20and%20Management%20Policy.pdf>
[Pressure Ulcer Policy](#)

<http://nww.iow.nhs.uk/guidelines/Nutrition%20Policy.pdf>
[Nutrition policy to prevent and manage malnutrition in adults](#)

<http://nww.iow.nhs.uk/guidelines/Care%20Programme%20Approach%20Policy.pdf>
[Care programme approach and standard care policy](#)

EPUAP (2009) and SHA (2012) Guidelines for the Prevention of Pressure Ulcers.



CARING FOR YOUR SKIN MATTERS

About the SSKIN Bundle

The SSKIN bundle is designed as a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers. It is meant for use across all areas of care in the community and will be instigated where a patient is deemed at risk of pressure ulcers as indicated by use of an assessment tool or by clinical judgement.

The object of the SSKIN bundle is to prompt consideration of all the health factors involved in maintaining skin integrity when planning care for a patient at risk of pressure damage. The aim of the plan should be to avoid pressure injury occurring at all, and where it does, to identify problems early in order to prevent deterioration and promote healing.

SSKIN

SURFACE

KEEP MOVING

INCONTINENCE

NUTRITION & HYDRATION

Glossary of terms

The following list gives a simple explanation of the meaning of some of the terms in the context they are meant within the SSKIN Bundle.

Achilles tendon – The tendon connecting calf muscles to the heel.

Arterial disease – A disease in which plaque builds up in the arteries, narrowing them and reducing blood flow through them.

Blanching – Tissue which whitens or pales with the application of pressure (and recovers its colour on release of pressure).

Concordance – Agreement from the patient regarding their care plan, used in place of compliance.

Emollients – Thick, greasy moisturising creams.

Erythema – Superficial reddening of the skin as a result of injury or irritation.

Eschar – A dry, dark scab.

Excoriation – Damage or remove part of the skin surface.

Foot drop – Extension of the foot caused by muscle wastage or paralysis, often occurs in bed bound patients.

Hyperaemic – An increase in the quantity of blood flow to a body part.

Maceration – Softening and breakdown of wet body tissues.

Oedema – An accumulation of fluid in the intercellular spaces of tissues; Swelling.

Osteomyelitis – Inflammation of the bone and bone marrow.

Palpable – Easily felt by sense of touch.

Recumbent position – Lying down; reclining.

Serum – (Blood serum) the watery proportion of blood which separates from the clot in coagulation.

Sero-Sanguinous – A pink serous fluid containing few red blood cells.

Slough – A layer or mass of dead tissue.

Stool sample – A sample of faeces.

Support surface – The surface on which the patient rests e.g. mattress or cushion.

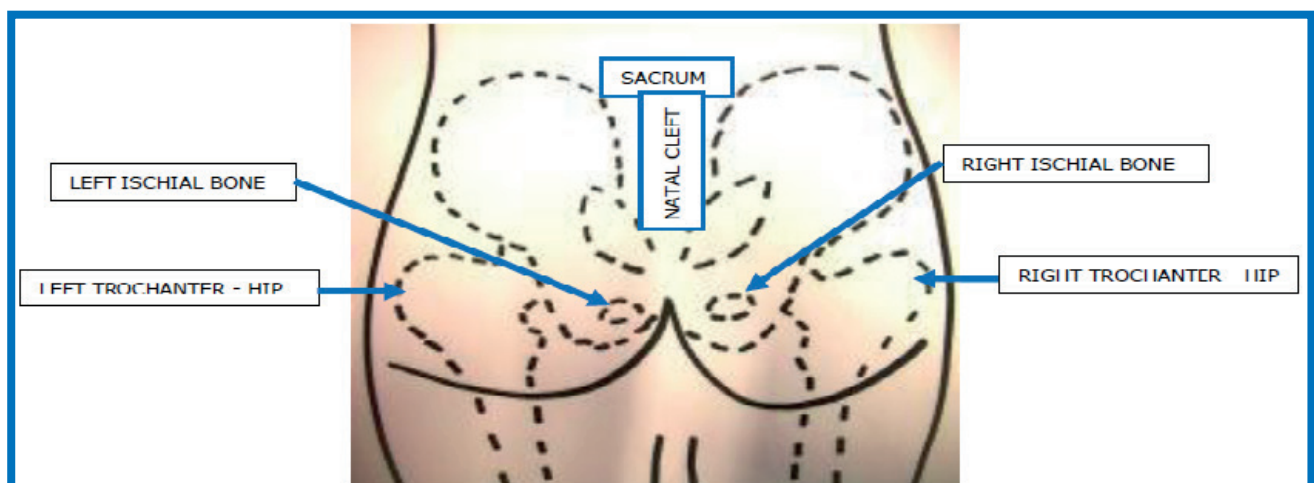
Skin Assessment, Monitoring and Care

Risk assessment

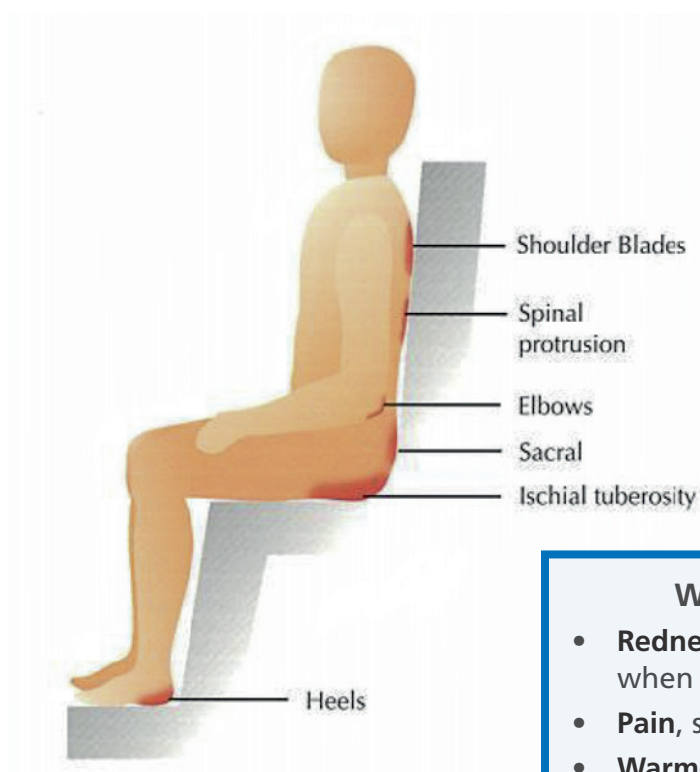
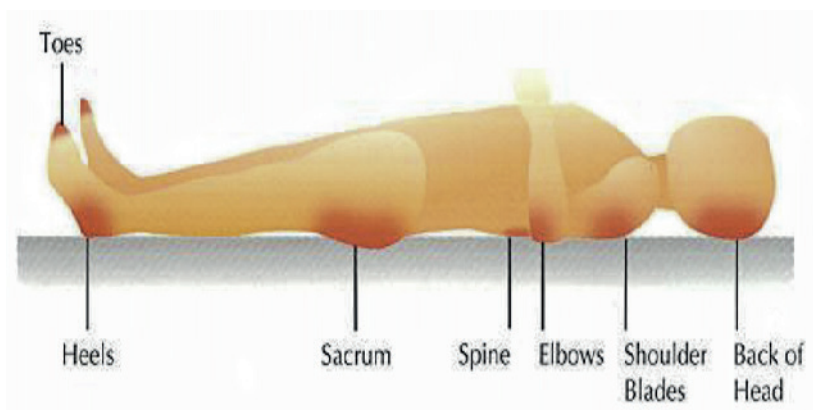
- All patients will be screened using the Waterlow score at first planned visit.
- Waterlow reassessment will be repeated weekly or at each visit if seen 3 monthly/6 monthly/ annually or if they have deterioration in their condition or on hospital discharge.
- Risk assessment should support **not replace** clinical judgement.
- A Waterlow score over 10 or clinical judgement that indicates the patient is at risk of pressure ulcer development indicates that a SSKIN bundle will be implemented.
- For patients at risk the patient and/or carer will be given an information leaflet (see end of section) and an information plan (see "Patient Information Plans").

Skin assessment (see following pages)

- Initial skin assessment by a registered nurse will be undertaken during Waterlow risk assessment.
- Patients and carers will be shown how to undertake the skin tolerance test to observe for early sign of tissue damage. The registered nurse completing the care plan will tell the patient and/or carer how often they expect this to be performed.
- The skin tolerance test is not reliable for patients with dark skin so observe for change in tissue temperature, texture, pain and discolouration and record this on the skin assessment.
- Skin damage will be classified using the grading adapted from the European Pressure Ulcer Advisory Panel (2009).
- The frequency of skin inspection by a registered nurse will be based on individual need according to risk status and will be recorded no more than once a day on the SSKIN Bundle.
- Wounds and skin conditions will be accurately recorded using wound measurements, anatomical location and photographs.
- The skin will be observed for damage from appliances, devices and tubing.
- The anatomical areas will be described accurately as per diagram below:



Have you checked your patient's most vulnerable pressure points today?



B – Buttocks
(ischial tuberosities)

E – Elbows/Ears

S – Sacrum
(bottom)

T – Trochanters
(hips)

S – Spine/
Shoulders

H – Heels

O – Occipital Area
(back of the head)

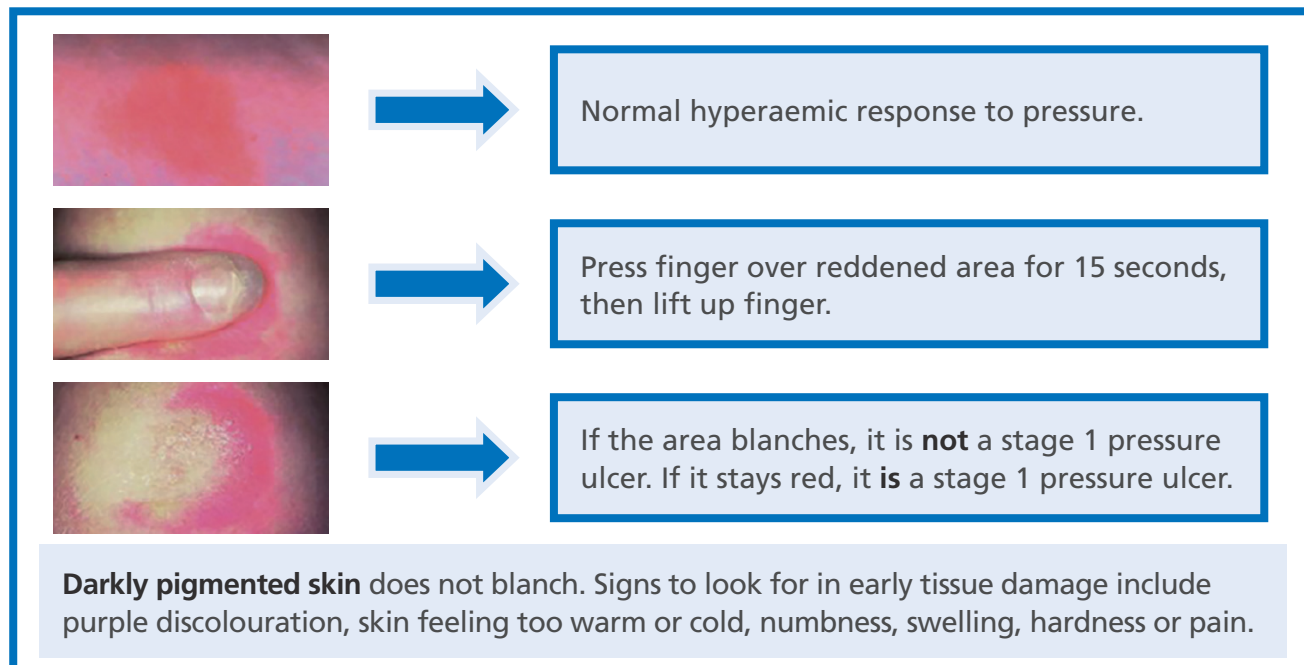
T – Toes

What to look and feel for?

- **Redness/erythema** – non-blanching when finger pressure applied
- **Pain**, soreness
- **Warmer** or **cooler** area over bony prominence
- **Boggy** feeling
- **Hardened** area
- **Discolouration** – dark red, purple, black
- **Broken skin/ulcer**

N.B. Document any changes & continue to monitor closely!!!

The Skin Tolerance Test



Reporting

All stages of pressure ulcers whether acquired or inherited Grades 1–4 will be reported via the organisation's incident and serious untoward incident reporting policies and procedures. A Root Cause Analysis (RCA) will be completed for all acquired Grade 3 and 4 pressure ulcers.

- All incident reports must include the site and stage of the ulcer, if the pressure ulcer is acquired or inherited and, if the information is available at the time, whether the reporting nurse believes the pressure ulcer to be avoidable or unavoidable.
- All incident reports will include if the pressure ulcer is **Acquired** or **Inherited**:
 - » Acquired pressure damage – damage that occurs whilst the patient is receiving care from Isle of Wight NHS Trust either as an inpatient or in the community
 - » Inherited pressure damage – pressure ulcer present on admission when admitted into services within Isle of Wight NHS Trust
- All acquired avoidable and unavoidable Grade 3 and 4 pressure ulcers will be reported as requiring investigation in line with organisational policy and procedures and Isle of Wight NHS Trust Guidelines.
- Avoidable – all pressure ulcers are deemed to be avoidable unless they meet the specific criteria listed below.
- Unavoidable – means that the individual developed a pressure ulcer even though their condition and pressure ulcer risk had been evaluated; goals and recognised standards of care that are consistent with individual needs have been implemented; the impact of these interventions had been monitored, evaluated and recorded and the approaches had been revised.
- All Grade 3 and 4 pressure ulcers will be referred to Tissue Viability Link Nurses. Once the link nurse has assessed, they may if they feel it is necessary to refer to the Nutrition and Tissue Viability Service for further advice.
- All patient's developing grade 3–4 pressure ulcers should be referred to a dietician.

Pressure ulcer classification (adapted from EPUAP, 2009)

Grade 1: Non-blanching erythema

Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, bluish tinge. Grade 1 may be difficult to detect in individuals with dark skin tones. May indicate an "at risk" persons.



SUPERFICIAL

Grade 2: Partial thickness

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. **Note that bruising may indicate deeper tissue injury.** This stage should not be used to describe skin tears, tape burns, moisture lesions, maceration or excoriation.



Grade 3: Full thickness

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. The depth of a Grade 3 pressure ulcer varies by anatomical location. The ear, occiput and malleolus do not have fatty tissue and Grade 3 ulcers can appear shallow. In contrast, fatty areas appear deeper. Bone/tendon is not visible or directly palpable.



DEEP

Grade 4: Full thickness

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 Grade 4 pressure ulcer varies by anatomical location as for Grade 3. Grade 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis likely to occur. Exposed bone/muscle is visible or directly palpable.



UNGRADEABLE

Ungradeable ulcer

Any pressure ulcer where depth cannot be discerned.

Purple localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure **and/or shear**. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. A thin blister may develop over a dark wound bed. The wound bed may become obscured by slough or eschar. Changes may be rapid exposing additional layers of tissue despite optimal treatment.



Moisture Lesion: not a pressure ulcer

Redness or partial thickness skin loss involving the epidermis, upper dermis or both. Caused by excessive moisture to the skin from urine, faeces or sweat. This is not a pressure ulcer and must not be confused with a Grade 2 pressure ulcer which is caused by pressure not moisture.



MOISTURE

Repositioning

- Patients who are identified at risk by either clinical judgement and/or the Waterlow Score will have a repositioning regime planned by a registered nurse.
- Assessment of mobility needs will include all aspects of movement including sitting times, ability to reposition and methods of transfer.
- Frequency of repositioning should be determined by patient's tissue tolerance, skin assessment and existing pressure damage.
- Repositioning should be influenced by the support surface and the patient risk status.
- Transfer aids should be used to reduce friction and shear.
- Avoid repositioning over existing erythema.
- Patients with existing sacral/buttocks tissue damage of Grade 1 and 2 should have a pressure relieving cushion and should not sit without being repositioned for more than 2 hours.
- Patients with Grade 3 and 4 sacral/buttock pressure damage ideally should not sit out, if this is essential for holistic care this should be around mealtimes only with a high risk alternating cushion.
- Principles of the 30° tilt can be used for patients in bed (see "Keep Moving").
- Chairs, seats and cushions need to provide the correct sitting height and position for the patient, to prevent increasing pressure, friction and shearing.

Equipment

- Refer to the equipment flowchart (see "Surface").
- Ensure at risk heels are off loaded and pressure is distributed evenly along the calf without putting pressure on the Achilles tendon particularly for patients with arterial disease, diabetes or oedema.
- Use pressure reducing pads over awkward areas.
- If a patient is a permanent wheelchair user, the wheelchair cushion should be provided by Wheelchair Services. Refer to Wheelchair Services if a further assessment of cushion needs is required, or for any concerns regarding foot rests.

Concordance

- Provide full explanations of pressure ulcer preventive care, including equipment in use, to the patients and carers. This must be supported with the patient information leaflet and information plans. Document that this has been done.
- Assess patient's mental capacity for understanding decisions about pressure ulcer prevention and where non-concordance is an issue.
- For patients who do not have capacity, preventative care must be delivered in their best interests.
- Discuss and record reasons why patients/carers are declining pressure redistributing equipment and are not able to follow the plan of care.

Skin Care

- When a non-blanching red area develops, remove pressure immediately and the patient should avoid being positioned on this area until it has resolved. A healthcare professional should be immediately informed that this skin change has been discovered.
- If this is not possible, pressure relieving equipment should be used to relieve pressure from the area.
- Do not massage areas of pressure damage.
- Use patting instead of rubbing when drying at risk skin.
- Use skin emollients instead of soap for cleansing to hydrate at risk skin and prevent drying.
- Protect skin with appropriate barrier products if exposed to excessive moisture.
- Follow moisture lesion guidance for identification and care of moisture lesions (see "Incontinence").
- Complete a full continence assessment with diagnosis and a treatment plan.
- Identify a toileting regime where appropriate.
- If continence pads are prescribed, ensure they fit correctly and that the product is changed appropriately using wetness indicators. Ensure use of recommended barrier creams only with incontinence pads. Oil based creams are not appropriate.

Patient centred care planning

Risk assessment

Equipment needs

Skin & continence assessment

Skin care

Undertake nutritional screening

Repositioning

Evaluate effectiveness

Only 6 points to prevent the pressure ulcer

1. All patients must have a Waterlow Risk Assessment and MUST Score on the first Community visit.
2. If a patient is at risk of pressure ulcers a SSKIN bundle must be implemented.
3. All patients must have a Waterlow risk reassessment weekly or at each visit if seen 3 monthly/6 monthly/annually or if they have deterioration in their condition or on hospital discharge.
4. The SSKIN bundle must be evaluated when the Waterlow is reassessed.
5. All patients at risk of pressure ulcer development must be provided with verbal and written explanations of the risk and avoidance care plan. All information provided to the patient and carers must also be documented.
6. The patient information plan must be completed and given to the patient or the carer.

If a patient has a pressure ulcer remember to do, document the following:

Waterlow score

Grade and location of the pressure ulcer

Wound assessment tool

Origin of the pressure ulcer whether acquired or inherited

Pressure relieving equipment the patient currently has, if none what has been ordered and the date it arrives

Repositioning regime advised

Dressing regime

Verbal advice given to the patient

Any written information given to the patient

Report all grades of pressure ulcers as a clinical incident and document the incident number in the patient's records

If the patient has a Grade 3 or 4 pressure ulcer remember:

Refer to Tissue Viability Link Nurse in the first instance

Refer to a dietician having completed the MUST tool

Consider if Hb and albumin need to be checked

If the ulcer is on the heel an ABPI (DOPPLER assessment) needs to be undertaken prior to any debridement

Complete an incident form and document the incident number in the patient's records – refer to incident reporting and SIRI policies and procedures

Organisation – acquired pressure ulcers will require a Root Cause Analysis

Pressure Ulcers – Safeguarding Triggers – Patients under a Care Provider

Safeguarding Duty Officer: 01983 814980

- Alerts/referrals: safeguarding.referrals@iow.gov.uk
- Out of hours referrals: 01983 821105

To determine if the identification of a pressure ulcer on an individual receiving professional support (in a care home, hospital or care agency including community nurses) should result in a safeguarding referral the following triggers should be considered.

IF IN DOUBT → Initiate Safeguarding Adults Procedures → Discuss with senior manager → Record decision and reasons for decision.

	Possibly NOT Safeguarding at this stage	Possibly Safeguarding	Definitely Safeguarding	
1. What is the severity (Grade) of the pressure ulcer?	Grade 2 pressure ulcer or below – care plan required	Several Grade 2 pressure ulcers/ Grade 3 to 4 pressure ulcers – consider question 2	Grade 4 and other issues of significant concern	Always clearly record decision and reasons for decision
2. Does the individual have mental capacity and have they been concordant with treatment? Has a capacity assessment been completed?	Has capacity and declined treatment Capacity assessment is recorded	Does not have capacity or capacity has not been assessed – continue to question 3	Assessed as NOT having capacity and treatment NOT provided	
3. Full assessment completed and care plan developed in a timely manner and care plan implemented?	Documentation and equipment available to demonstrate full assessment completed, care plan developed and implemented	Documentation and equipment NOT fully available to demonstrate full assessment completed, care plan developed or care plan implemented BUT general care regime (e.g. nutrition, hydration) not of concern – continue to question 4	Little or no documentation available to demonstrate a full assessment has been completed, or care plan implemented AND general care regime (e.g. nutrition, hydration) is of concern	Pressure Ulcers – Safeguarding Triggers – Patients with Unpaid Carers
4. This incident is part of a trend or pattern – there have been other similar incidents with this individual or others	Evidence suggests this is an isolated incident	There have been other similar incidents	Evidence demonstrates this is a pattern or trend	
	NOT SAFEGUARDING	If 2 or more of the above apply – SAFEGUARDING	SAFEGUARDING	

To determine if the identification of a pressure ulcer on an individual with no professional support (i.e. the only support available is from an unpaid carer/ family member) should result in a safeguarding referral the following steps should be considered.

IF IN DOUBT → Initiate Safeguarding Adults Procedures → Discuss with senior manager → Record decision and reasons for decision.

Pressure Ulcers – Safeguarding Triggers – Patients with Unpaid Carers

Safeguarding Duty Officer: 01983 814980

- Alerts/referrals: safeguarding.referrals@iow.gov.uk
- Out of hours referrals: 01983 821105

To determine if the identification of a pressure ulcer on an individual with no professional support (i.e. the only support available is from an unpaid carer/family member) should result in a safeguarding referral the following triggers should be considered.

IF IN DOUBT → Initiate Safeguarding Adults Procedures → Discuss with senior manager → Record decision and reasons for decision.

	Possibly NOT Safeguarding at this stage	Possibly Safeguarding	Definitely Safeguarding
1. What is the severity (Grade) of the pressure ulcer?	Grade 2 pressure ulcer or below – care plan required	Several Grade 2 pressure ulcers/ Grade 3 to 4 pressure ulcers – consider question 2	Grade 4 and other issues of significant concern
2. Does the individual have mental capacity and have they been concordant with treatment? Has a capacity assessment been completed?	Has capacity and declined treatment Capacity assessment is recorded	Does not have capacity or capacity has not been assessed – continue to question 3	Assessed as NOT having capacity and treatment NOT provided
3. Unpaid carer raised concerns and sought support at an appropriate time	Evidence available to show concerns raised and support sought – e.g. from GP, DN, SW	Evidence NOT CLEAR that concerns were raised or support sought in a timely manner	No support sought
3. Full assessment completed and care plan developed in a timely manner and care plan implemented?	Evidence available to show unpaid carer cooperated with assessment and has implemented care plan	Evidence of partial cooperation or implementation of care plan – some aspects may have been declined, e.g. certain equipment	NO cooperation and refusal to implement care plan and/or purposeful neglect
4. This incident is part of a trend or pattern – there have been other similar incidents or other areas of concern	Evidence suggests this is an isolated incident	There have been other similar incidents or areas of concern	Evidence demonstrates this is a pattern or trend
	NOT SAFEGUARDING	If 2 or more of the above apply – SAFEGUARDING	SAFEGUARDING

Always clearly record decision and reasons for decision.

Waterlow score assesment tool and Guidelines

Patient

Waterlow pressure ulcer risk assessment scoring chart

IW/NHS number	Date											
Build/weight for height (score one category)	Average (BMI 20–24.9)	0	0	0	0	0	0	0	0	0	0	0
	Above average (BMI 25–29.9)	1	1	1	1	1	1	1	1	1	1	1
	Obese (BMI >30)	2	2	2	2	2	2	2	2	2	2	2
	Below average (BMI <20) BMI = Wt (Kg)/Height (metres squared)	3	3	3	3	3	3	3	3	3	3	3
Continenence (score one category)	Complete/catheterised	0	0	0	0	0	0	0	0	0	0	0
	Urinary incontinence	1	1	1	1	1	1	1	1	1	1	1
	Faecal incontinence	2	2	2	2	2	2	2	2	2	2	2
	Urinary/faecal incontinence	3	3	3	3	3	3	3	3	3	3	3
Skin type/visual risk areas (score all that apply)	Healthy	0	0	0	0	0	0	0	0	0	0	0
	Tissue paper	1	1	1	1	1	1	1	1	1	1	1
	Dry	1	1	1	1	1	1	1	1	1	1	1
	Oedematous	1	1	1	1	1	1	1	1	1	1	1
	Clammy/pyrexia	1	1	1	1	1	1	1	1	1	1	1
	Discoloured, Grade 1	2	2	2	2	2	2	2	2	2	2	2
	Broken/spots, Grade 2–4	3	3	3	3	3	3	3	3	3	3	3
Mobility (score one category)	Fully	0	0	0	0	0	0	0	0	0	0	0
	Restless/fidgety	1	1	1	1	1	1	1	1	1	1	1
	Apathetic	2	2	2	2	2	2	2	2	2	2	2
	Restricted	3	3	3	3	3	3	3	3	3	3	3
	Bedbound e.g. traction	4	4	4	4	4	4	4	4	4	4	4
	Chairbound e.g. wheelchair	5	5	5	5	5	5	5	5	5	5	5
Gender/age (score one separately)	Male	1	1	1	1	1	1	1	1	1	1	1
	Female	2	2	2	2	2	2	2	2	2	2	2
	14–49	1	1	1	1	1	1	1	1	1	1	1
	50–64	2	2	2	2	2	2	2	2	2	2	2
	65–74	3	3	3	3	3	3	3	3	3	3	3
	75–80	4	4	4	4	4	4	4	4	4	4	4
	81+	5	5	5	5	5	5	5	5	5	5	5

Malnutrition screening tool (MST)

A – has patient lost weight recently?	Yes – Go to B No – Go to C Unsure – Go to C and score 2											
B – Weight loss score	0.5–5Kg	1	1	1	1	1	1	1	1	1	1	1
	5–10Kg	2	2	2	2	2	2	2	2	2	2	2
	10–15Kg	3	3	3	3	3	3	3	3	3	3	3
	>15Kg	4	4	4	4	4	4	4	4	4	4	4
	Unsure	2	2	2	2	2	2	2	2	2	2	2
C – Patient eating poorly or lack of appetite	No	0	0	0	0	0	0	0	0	0	0	0
	Yes	1	1	1	1	1	1	1	1	1	1	1
	Unsure	2	2	2	2	2	2	2	2	2	2	2

Special risks (score all that apply)

Tissue malnutrition	Terminal cachexia	8	8	8	8	8	8	8	8	8	8	8
	Multiple organ failure	8	8	8	8	8	8	8	8	8	8	8
	Single organ failure (resp, renal, cardiac)	5	5	5	5	5	5	5	5	5	5	5
	Peripheral vascular disease	5	5	5	5	5	5	5	5	5	5	5
	Anaemia	2	2	2	2	2	2	2	2	2	2	2
	Smoking	1	1	1	1	1	1	1	1	1	1	1
Neurological deficit	Diabetes/MS/CVA	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6
	Motor/sensory	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6
	Paraplegia (max of 6)	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6	4–6
Major surgery or trauma	Orthopaedic/spinal	5	5	5	5	5	5	5	5	5	5	5
	On table >2 hours	5	5	5	5	5	5	5	5	5	5	5
	On table >6 hours	8	8	8	8	8	8	8	8	8	8	8
Medication	Cytotoxics/long term/high dose steroids, anti-inflammatories	4	4	4	4	4	4	4	4	4	4	4
Total												
Signed												

Scores on table can be discounted after 48 hours

Pressure area care: patient information leaflet

What can I do to avoid pressure ulcers?

There are several ways you can reduce the risk of pressure ulcers.

Keep moving

Changing your position regularly helps keep blood flowing. If you have reduced movement the health care team looking after you will assist you with regular turns in addition to providing specialist mattresses, cushions etc.

Look for signs of damage

Check your skin for pressure damage at least once a day. Look for skin that doesn't go back to its normal colour after you have taken your weight off it. Do not continue to lie on skin that is redder or darker than usual. Also watch out for blisters, dry patches or breaks in the skin.

Protect your skin

wash your skin using warm water or pH neutral skin cleansers. Do not use heavily perfumed soap or talcum powder, as these can soak up the skin's natural oils leading to vulnerable dry areas. If you suffer from incontinence please inform your health care team as they can assess the best way to deal with the problems. Rubbing/massaging skin is bad for it.

Eat a well-balanced diet

make sure you eat a healthy balanced diet and drink plenty of fluids. Extra protein may help.

Author: Tissue Viability Team, Buckinghamshire Hospitals.
Design: Public Relations Department, Winchester and Eastleigh Healthcare NHS Trust

What should I do if I suspect a pressure ulcer?

Tell your doctor or nurse as soon as possible and follow the advice they give you.

Eat and drink as medically advised.

Name _____

You are at low / medium / high risk of pressure ulcers

If you require a translation of this leaflet, please ask your nurse.



no needless skin breakdown

**Pressure Area
Care**
a guide for patients

This leaflet contains general information.

If there is anything else you need to know, please speak to your nurse or doctor.

**Patient Safety
Federation** safe care for all

What is a pressure ulcer?

A pressure ulcer is an area of damage to the skin and underlying tissue.

They are sometimes known as pressure sores or bed sores.

What causes a pressure ulcer

Pressure ulcers are caused by poor circulation to tissues due to a combination of the following factors.

Pressure

Body weight and some equipment (e.g. anti-thrombosis stockings) can squash the skin and other tissues where parts are under pressure. This reduces the blood supply to the area and can lead to tissue damage.

Shearing

Sliding or slumping down the bed/chair can damage the skin and deeper layers of tissue.

Friction

Poor moving and handling methods can remove the top layers of skin. Repeated friction can increase your risk.

Who is most at risk of developing pressure ulcers?

You may be at risk of developing pressure ulcers for a number of reasons including the following.

Problems with movement

If your ability to move is limited you don't get enough oxygen to the parts under pressure.

Poor circulation

Vascular disease or smoking reduces your circulation.

Moist skin

You may be at increased risk if your skin is too damp, due to incontinence, sweat or a weeping wound. It is important that your skin is kept clean and healthy.

Lack of sensitivity to pain or discomfort

Conditions such as diabetes, stroke, nerve/muscle disorders etc reduce the normal sensations that usually prompt you, or enable you to move. Some treatments (eg epidural pain relief, medication, operations) reduce your sensitivity to pain or discomfort so that you are not aware of the need to move.

Previous tissue damage

Scar tissue will have lost some of its previous strength and is more prone to breakdown.

Inadequate diet or fluid intake

Lack of fluid may dehydrate your tissues. Weight gain or loss can affect the pressure distribution over bony points and healing.

Risk assessment

To assess your risk of developing pressure ulcers, a member of your health care team will examine/assess you and ask you some questions. This will help to identify if you require a specialised equipment or other forms of care, and will assist in providing for your individual needs.

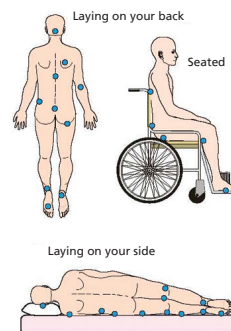
What are the early signs of a pressure ulcer?

You will notice the following signs:

- change in skin colour, redder or darker
- heat or cold
- discomfort or pain
- blistering
- skin damage.

Without appropriate intervention the damage may worsen, developing into hard black tissue or an open wound.

Common locations of pressure ulcers

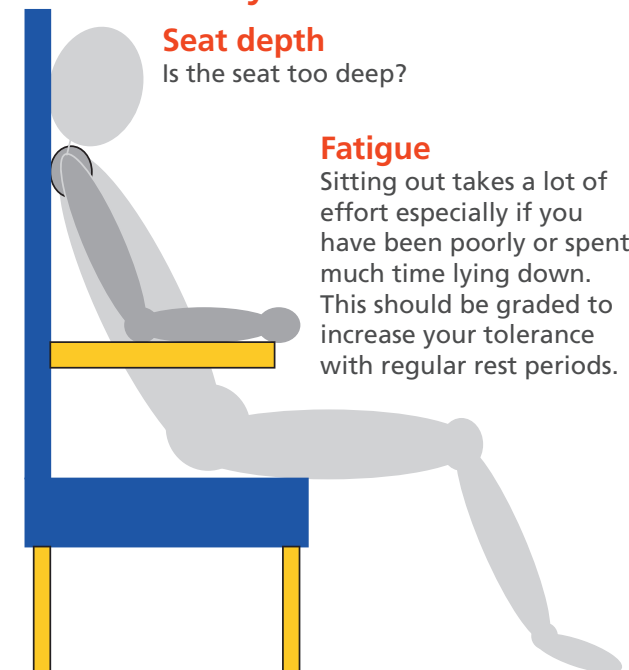


Reference: Whiting NJ. (2009) Skin assessment of patients at risk of pressure ulcers. Nursing Standard vol 24 no. 10 pages 40 - 44

Mattresses and cushions

- Patients who are assessed as at risk should be cared for on pressure reducing or pressure relieving equipment.
 - » Pressure reducing equipment (for lower risk patients) is designed to distribute the body weight over as large as possible skin surface area – e.g. specialist and memory foams or static air mattresses.
 - » Pressure relieving equipment is designed to redistribute body weight periodically over different areas of skin – e.g. dynamic mattresses and cushions.
- At risk patients who are not bedbound should be assessed for a mattress **AND** cushion.
- Patients who are seated for long periods are at higher risk of pressure injury, particularly if unsupported, as their body weight is concentrated over their buttocks and feet. These patients will need repositioning even more frequently, or standing periodically to allow a few minutes tissue recovery.
- When seated, ensure patients back and legs/feet are fully supported by cushions or furniture to allow for weight distribution and comfort. Patients left poorly positioned are more likely to develop pressure damage and permanent postural problems/fixed deformities.
- Bear in mind that adding a pressure relieving cushion will increase seat height and reduce armrest height. You may need to add extra support under feet and arms or remove the normal seat cushion and replace it with the pressure relieving one.
- Nutrition and hydration can be compromised by poor position, as patients who are unsupported or reclined too far, will find swallowing more difficult and are at increased risk of aspiration.
- Patients who lean or lie on one side due to weakness, anatomy, posture or preference are at increased risk of pressure injury on that side and should be assessed for appropriate support and encouraged to move or reposition more frequently. Consider additional equipment such as arm rest covers etc.

Why do I slide?



Seat depth

Is the seat too deep?

Fatigue

Sitting out takes a lot of effort especially if you have been poorly or spent much time lying down. This should be graded to increase your tolerance with regular rest periods.

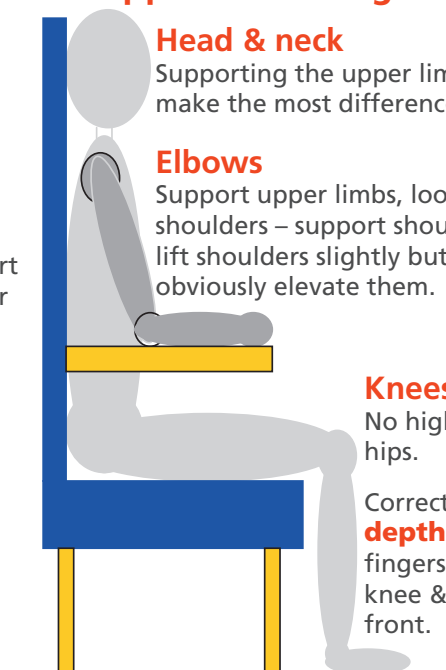
Support lumbar spine

Fixed posture

Some people have developed a fixed posture & sit leaning back, with their head forwards. This needs appropriately supporting, you cannot correct it.

If in doubt please ask

Supportive sitting



Head & neck

Supporting the upper limbs will make the most difference to this.

Elbows

Support upper limbs, look at shoulders – support should lift shoulders slightly but not obviously elevate them.

Knees

No higher than hips.

Correct **seat depth** – 2 fingers behind knee & seat front.

Feet

On the floor or safe supporting surface. Pillows/towel rolls/blanket rolls can provide additional support.

Be aware of increasing heat & moisture...

Think spread the load



HEAD...

It's heavy; supporting the elbows and forearms helps take the weight. If someone is struggling to support their head this will encourage a kyphotic posture (c shape spine); it may cause long term deformity if not assessed and managed correctly.

SHOULDERS...

Allow shoulders to roll back, arm rests should be high enough to support but not obviously raise shoulders up to ears. People shouldn't have to lean to reach an armrest

KNEES...

Not higher than hips when sitting. Two fingers should fit behind back of knee and front of seat.

& TOES ...

Keep feet on the floor, or supported on a stable/safe surface.



If in doubt shout...

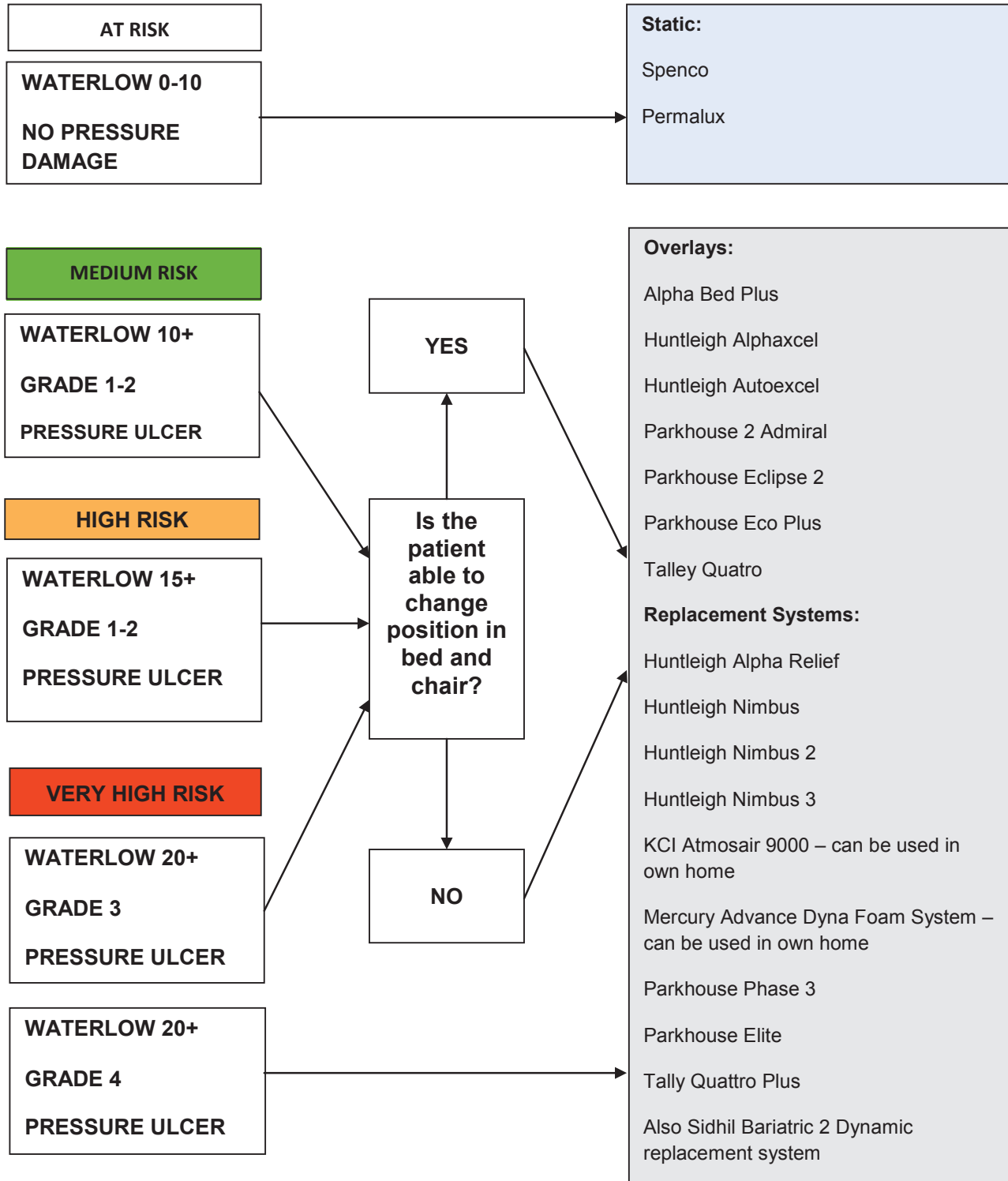


If you have supported the individual but are concerned that you haven't been able to improve things for them please ask for help.

They may well need a postural assessment to establish the pelvis position and level of flexibility/fixing of spine.

Physiotherapists, Occupational Therapists and staff with rehab skills should be able to support/advise on supported sitting

A guide for the provision of support surfaces



Keep Moving – Reposition

Patients who are unable to move or reposition themselves must be helped to do so frequently.

- Patients who are identified at risk by either clinical judgement and/or the Waterlow Score will have a repositioning regime planned by a registered nurse.
- Assessment of mobility needs will include all aspects of movement including sitting times, ability to reposition and methods of transfer.
- Frequency of repositioning should be determined by patient's tissue tolerance, skin assessment and existing pressure damage.
- Repositioning should be influenced by the support surface and the patient risk status.
- Transfer aids should be used to reduce friction and shear.
- Avoid repositioning over existing erythema.
- Patients with existing sacral/buttocks tissue damage of Grade 1 and 2 should have a pressure relieving cushion and should not sit without being repositioned for more than 2 hours.
- Patients with Grade 3 and 4 sacral/buttock pressure damage ideally should not sit out, if this is essential for holistic care this should be around mealtimes only with a high risk alternating cushion.
- Principles of the 30° tilt can be used for patients in bed (see diagram).
- Chairs, seats and cushions need to provide the correct sitting height and position for the patient, to prevent increasing pressure, friction and shearing.
- Be aware that patients who experience problems that restrict their mobility eg. Leg ulcers, will be at higher risk of developing pressure ulcers.



Principles of the 30° tilt

The following pictures illustrate the procedure whilst the patient is lying in the recumbent position. The bed should be raised to waist level. Two extra pillows are necessary for this procedure and a third pillow can be used lengthways to support the other leg if required.

Stage 1

The patient should be lying in the middle of the bed, with their head comfortably supported by two pillows. The lower pillow should be positioned to ensure support for the neck.



Stage 2

The patient should be rolled towards one side of the bed. A pillow is positioned to support the lumbar region and shoulder. This tilts the patient on to one buttock and lifts the sacrum clear of the mattress. Ensure the support pillow is not placed under the sacrum or buttock.



Stage 3

The full length of the leg should be supported by "moulding" a pillow around it. The heel should be overhanging the end of the pillow to relieve pressure and care should be taken to avoid pressure being applied to the back of the leg or calf.



Stage 4

An additional pillow may be used to support the other leg, if required. Tuck the pillow behind the Achilles tendon and ensure that the space behind the knee is supported by the edge of the pillow. Do not use the full bulk of the pillow to support this leg as this will distort the bodies' alignment and cause the patient discomfort. Again, the heel should be clear of the mattress.



Stage 5

The following picture demonstrates the final position of the patient

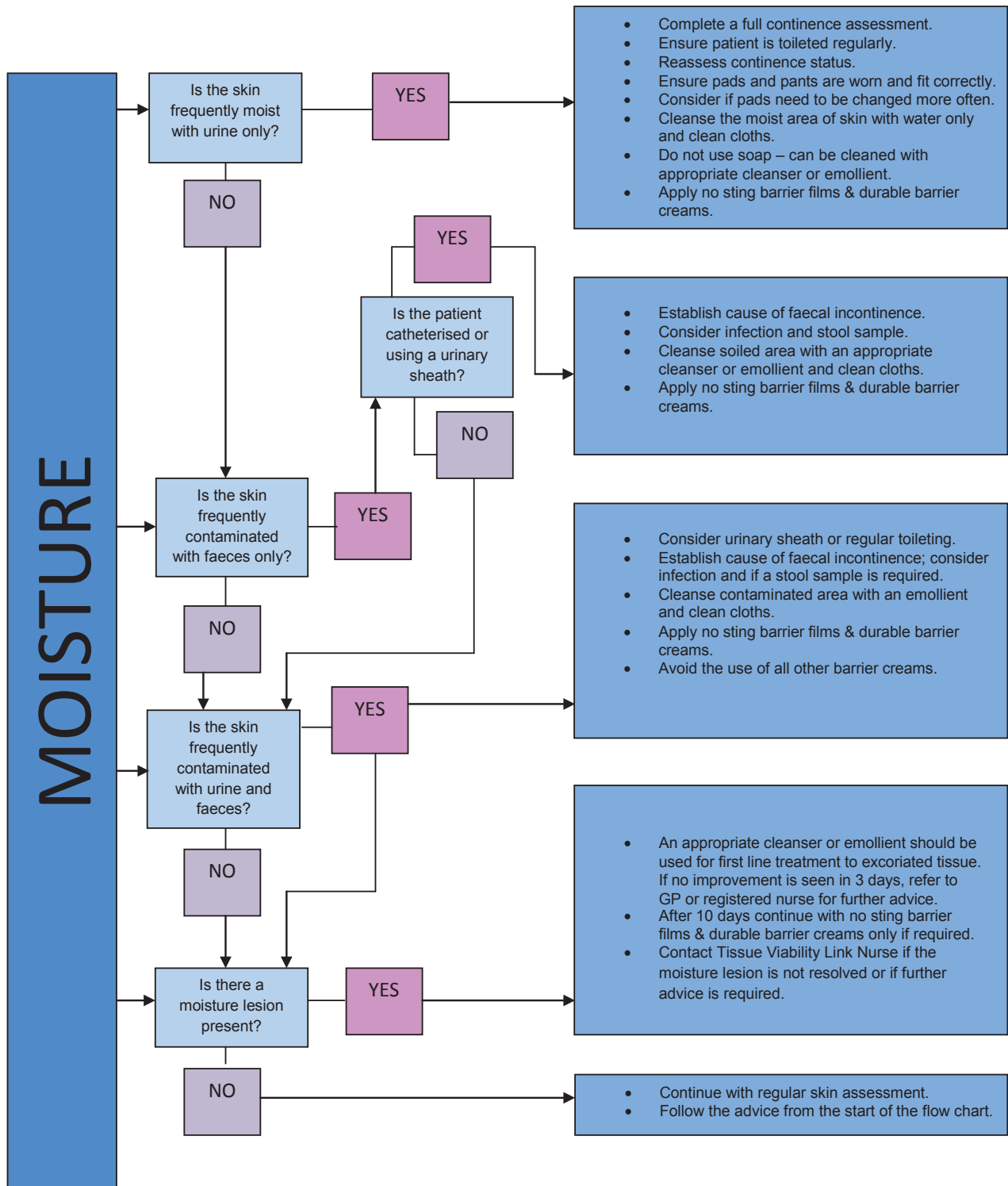


N.B. In the event of foot drop occurring, please refer to physiotherapy for further advice.

Incontinence

- Skin surface is normally slightly acidic and the content of urine and faeces are alkaline, so when left in contact with the skin for any length of time they cause damage which is similar in nature to a chemical burn. These can be very painful despite appearing only superficial.
- The best treatment for prevention of these moisture lesions is an effective barrier cream. The use of oily creams and those containing heavy metals (nappy type creams) is not recommended for use with pads of any sort as they transfer to the pad and reduce its absorbency – leaving more moisture against the patient's skin.
- The most effective creams to use for patients who are incontinent and wear pads are the silicone based ones which form a complete skin barrier and adhere to the skin without any transference to the pad.
- Patient's with skin that is already damaged are much more prone to pressure injury and skin breakdown.

Flow chart for the prevention and management of moisture lesions



Assessment of Nutritional Status and level of Hydration

The nutritional state and hydration level of a patient is crucial to the health of their skin and their ability to heal.

- All patients will be screened at first contact using the Community Malnutrition Universal Screening Tool, (MUST).
- Following MUST guidance, refer to GP for nutritional support if indicated.
- Risk assessment should support, not replace clinical judgement.
- Also visibly assess the patient's clothing, jewellery, dentures etc, in consideration of recent weight loss.
- Observe the patients skin state and oral mucosa for signs of dehydration.
- If indicated use the GULP Assessment to monitor fluid consumption and gauge output.
- Practical advice on nutritional support to improve dietary intake should be provided in line with the Isle of Wight NHS Trust's Nutrition Policy.
- Give patient information leaflets as required and indicated. (See those enclosed)
- All patients with a Grade 3 or 4 pressure ulcer should be referred to dietetic services.

Malnutrition Assessment for Community Patients (MUST Score)

Name Date of birth IW/NHS number	<h3 style="margin: 0;">Nutritional Assessment</h3> <p style="color: red; font-weight: bold; margin-top: 10px;">To be completed if deemed necessary following Activities of Living Assessment.</p>
--	---

MUST assessment

1. BMI score	2. Unplanned weight loss in last 3-6 months	3. Acute disease effect score	Risk scoring
BMI > 20 [over 30 obese] = 0	< 5% = 0	Add score of 2 if there has been or is likely to be no nutritional intake for 5 days or more	0 Low risk
BMI 18.5 – 20 = 1	5 – 10% = 1		1 – 2 Medium – High risk
BMI < 18.5 = 2	> 10% = 2		3 or more Very high risk
MUAC < 23.5 = 2			

Pre illness weight Measured Reported

Date										
Time of weight	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM	
Current weight										
Weight measured [M]/reported [R]	M	R	M	R	M	R	M	R	M	R
Type of scales used										
Height										
Height measured [M]/reported [R]	M	R	M	R	M	R	M	R	M	R
MUAC left or right arm										
BMI [kg/m ²]										
1. BMI score										
2. Weight loss score										
3. Acute disease score										
1+2+3= Total MUST score										
Risk rating										
Review date due										
Signature										
Print name & designation										
Date										

Low risk Action plan	Medium – High risk Action plan	Very high risk Action plan
<ul style="list-style-type: none"> Weigh patient & repeat MUST assessment: Care homes – monthly Community – quarterly 	<ul style="list-style-type: none"> Observe Give leaflet 1 if score 1 & advise Give leaflet 1 & 2 if score 2 & advise Document dietary intake for 3 days if in care home or ask patient to keep a food diary If improved or adequate intake – little clinical concern, if no improvement – clinical concern Advice on fortifying food and increasing calorific intake (see advice sheet) Repeat screening: Care homes – at least weekly Community – at least monthly 	<ul style="list-style-type: none"> Treat (unless detrimental or no benefit is expected from nutritional support e.g. imminent death) Give leaflets 1, 2 & 3 Give advice to improve and increase overall nutritional intake Refer to GP for prescription of supplements if patient unable to increase calorific intake by fortifying food or additional snacks Monitor and review care plan: Care homes – monthly Community – monthly



BAPEN
Association of Clinical Nutritionists
www.bapen.org.uk

Step 2 – Weight loss score

Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%
-----------------------------------	--------------------------------------	------------------------------------

Weight 3 to 6 months ago

kg	Less than (kg)	Between (kg)	More than (kg)
30	31.6 - 33.3	33.3	33.3
31	32.6 - 34.4	34.4	34.4
32	33.7 - 35.6	35.6	35.6
33	34.7 - 36.7	36.7	36.7
34	35.8 - 37.7	37.8	37.8
35	36.8 - 38.9	38.9	38.9
36	37.9 - 40.0	40.0	40.0
37	38.9 - 41.2	41.1	41.1
38	40.0 - 42.2	42.2	42.2
39	41.1 - 43.3	43.3	43.3
40	42.1 - 44.4	44.4	44.4
41	43.2 - 45.6	45.6	45.6
42	44.2 - 46.6	46.7	46.7
43	45.3 - 47.8	47.8	47.8
44	46.3 - 48.9	48.9	48.9
45	47.4 - 50.0	50.0	50.0
46	48.4 - 51.1	51.1	51.1
47	49.5 - 52.2	52.2	52.2
48	50.5 - 53.3	53.3	53.3
49	51.6 - 54.4	54.4	54.4
50	52.6 - 55.6	55.6	55.6
51	53.7 - 56.7	56.7	56.7
52	54.7 - 57.8	57.8	57.8
53	55.8 - 58.9	58.9	58.9
54	56.8 - 60.0	60.0	60.0
55	57.9 - 61.1	61.1	61.1
56	58.9 - 62.2	62.2	62.2
57	60.0 - 63.3	63.3	63.3
58	61.1 - 64.4	64.4	64.4
59	62.1 - 65.6	65.6	65.6
60	63.2 - 66.7	66.7	66.7
61	64.2 - 67.8	67.8	67.8
62	65.3 - 68.9	68.9	68.9
63	66.3 - 70.0	70.0	70.0
64	67.4 - 71.1	71.1	71.1

Current weight

Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%
-----------------------------------	--------------------------------------	------------------------------------

Weight 3 to 6 months ago

kg	Less than (kg)	Between (kg)	More than (kg)
65	68.4 - 72.2	72.2	72.2
66	69.5 - 73.3	73.3	73.3
67	70.5 - 74.4	74.4	74.4
68	71.6 - 75.6	75.6	75.6
69	72.6 - 76.7	76.7	76.7
70	73.7 - 77.8	77.8	77.8
71	74.7 - 78.9	78.9	78.9
72	75.8 - 80.0	80.0	80.0
73	76.8 - 81.1	81.1	81.1
74	77.9 - 82.2	82.2	82.2
75	78.9 - 83.3	83.3	83.3
76	80.0 - 84.4	84.4	84.4
77	81.1 - 85.6	85.6	85.6
78	82.1 - 86.7	86.7	86.7
79	83.2 - 87.8	87.8	87.8
80	84.2 - 88.9	88.9	88.9
81	85.3 - 90.0	90.0	90.0
82	86.3 - 91.1	91.1	91.1
83	87.4 - 92.2	92.2	92.2
84	88.4 - 93.3	93.3	93.3
85	89.5 - 94.4	94.4	94.4
86	90.5 - 95.6	95.6	95.6
87	91.6 - 96.7	96.7	96.7
88	92.6 - 97.8	97.8	97.8
89	93.7 - 98.9	98.9	98.9
90	94.7 - 100.0	100.0	100.0
91	95.8 - 101.1	101.1	101.1
92	96.8 - 102.2	102.2	102.2
93	97.9 - 103.3	103.3	103.3
94	98.9 - 104.4	104.4	104.4
95	100.0 - 105.6	105.6	105.6
96	101.1 - 106.7	106.7	106.7
97	102.1 - 107.8	107.8	107.8
98	103.2 - 108.9	108.9	108.9
99	104.2 - 110.0	110.0	110.0

Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%
-----------------------------------	--------------------------------------	------------------------------------

Weight 3 to 6 months ago

kg	Less than (kg)	Between (kg)	More than (kg)
100	105.3 - 111.1	111.1	111.1
101	106.3 - 112.2	112.2	112.2
102	107.4 - 113.3	113.3	113.3
103	108.4 - 114.4	114.4	114.4
104	109.5 - 115.6	115.6	115.6
105	110.5 - 116.7	116.7	116.7
106	111.6 - 117.8	117.8	117.8
107	112.6 - 118.9	118.9	118.9
108	113.7 - 120.0	120.0	120.0
109	114.7 - 121.1	121.1	121.1
110	115.8 - 122.2	122.2	122.2
111	116.8 - 123.3	123.3	123.3
112	117.9 - 124.4	124.4	124.4
113	118.9 - 125.6	125.6	125.6
114	120.0 - 126.7	126.7	126.7
115	121.1 - 127.8	127.8	127.8
116	122.1 - 128.9	128.9	128.9
117	123.2 - 130.0	130.0	130.0
118	124.2 - 131.1	131.1	131.1
119	125.3 - 132.2	132.2	132.2
120	126.3 - 133.3	133.3	133.3
121	127.4 - 134.4	134.4	134.4
122	128.4 - 135.6	135.6	135.6
123	129.5 - 136.7	136.7	136.7
124	130.5 - 137.8	137.8	137.8
125	131.6 - 138.9	138.9	138.9
126	132.6 - 140.0	140.0	140.0
127	133.7 - 141.1	141.1	141.1
128	134.7 - 142.2	142.2	142.2
129	135.8 - 143.3	143.3	143.3
130	136.8 - 144.4	144.4	144.4
131	137.9 - 145.6	145.6	145.6
132	138.9 - 146.7	146.7	146.7
133	140.0 - 147.8	147.8	147.8
134	141.1 - 148.9	148.9	148.9

Current weight

Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%
-----------------------------------	--------------------------------------	------------------------------------

Weight 3 to 6 months ago

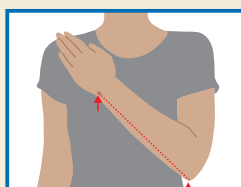
kg	Less than (kg)	Between (kg)	More than (kg)
135	142.1 - 150.0	150.0	150.0
136	143.2 - 151.0	151.1	151.1
137	144.2 - 152.2	152.2	152.2
138	145.3 - 153.3	153.3	153.3
139	146.3 - 154.4	154.4	154.4
140	147.4 - 155.6	155.6	155.6
141	148.4 - 156.7	156.7	156.7
142	149.5 - 149.5	157.8	157.8
143	150.5 - 158.9	158.9	158.9
144	151.6 - 160.0	160.0	160.0
145	152.6 - 161.1	161.1	161.1
146	153.7 - 162.2	162.2	162.2
147	154.7 - 163.3	163.3	163.3
148	155.8 - 164.4	164.4	164.4
149	156.8 - 165.6	165.6	165.6
150	157.9 - 166.7	166.7	166.7
151	158.9 - 166.7	167.8	167.8
152	160.0 - 168.7	168.9	168.9
153	161.1 - 170.0	170.0	170.0
154	162.1 - 171.1	171.1	171.1
155	163.2 - 172.2	172.2	172.2
156	164.2 - 173.3	173.3	173.3
157	165.3 - 174.4	174.4	174.4
158	166.3 - 175.6	175.6	175.6
159	167.4 - 176.7	176.7	176.7
160	168.4 - 177.8	177.8	177.8
161	169.5 - 178.9	178.9	178.9
162	170.5 - 180.0	180.0	180.0
163	171.6 - 181.1	181.1	181.1
164	172.6 - 182.2	182.2	182.2
165	173.7 - 183.3	183.3	183.3
166	174.7 - 184.4	184.4	184.4
167	175.8 - 185.6	185.6	185.6
168	176.8 - 186.7	186.7	186.7
169	177.9 - 187.8	187.8	187.8



Alternative measurements: instructions and tables

If height cannot be obtained, use length of forearm (ulna) to calculate height using tables below. (See *The 'MUST' Explanatory Booklet* for details of other alternative measurements (knee height and demispans) that can also be used to estimate height).

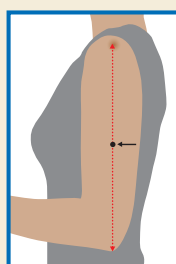
Estimating height from ulna length



Measure between the point of the elbow (olecranon process) and the midpoint of the prominent bone of the wrist (styloid process) (left side if possible).

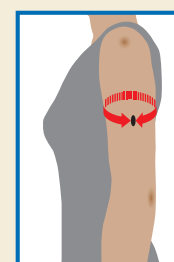
HEIGHT (m)	Men (<65 years)	1.94	1.93	1.91	1.89	1.87	1.85	1.84	1.82	1.80	1.78	1.76	1.75	1.73	1.71
	Men (≥65 years)	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67
Ulna length (cm)		32.0	31.5	31.0	30.5	30.0	29.5	29.0	28.5	28.0	27.5	27.0	26.5	26.0	25.5
HEIGHT (m)	Women (<65 years)	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.70	1.69	1.68	1.66
	Women (≥65 years)	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.66	1.65	1.63
HEIGHT (m)	Men (<65 years)	1.69	1.67	1.66	1.64	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.49	1.48	1.46
	Men (≥65 years)	1.65	1.63	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48	1.46	1.45
Ulna length (cm)		25.0	24.5	24.0	23.5	23.0	22.5	22.0	21.5	21.0	20.5	20.0	19.5	19.0	18.5
HEIGHT (m)	Women (<65 years)	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47
	Women (≥65 years)	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.44	1.42	1.40

Estimating BMI category from mid upper arm circumference (MUAC)



The subject's left arm should be bent at the elbow at a 90 degree angle, with the upper arm held parallel to the side of the body. Measure the distance between the bony protrusion on the shoulder (acromion) and the point of the elbow (olecranon process). Mark the mid-point.

Ask the subject to let arm hang loose and measure around the upper arm at the mid-point, making sure that the tape measure is snug but not tight.



If MUAC is <23.5 cm, BMI is likely to be <20 kg/m².
If MUAC is >32.0 cm, BMI is likely to be >30 kg/m².

The use of MUAC provides a general indication of BMI and is not designed to generate an actual score for use with 'MUST'. For further information on use of MUAC please refer to *The 'MUST' Explanatory Booklet*.

Guidance on using resources in conjunction with MUST screening

The following resources are available for use with your clients that have identified as being malnourished or at risk following MUST screening:

- Handy hints to improve your nutritional intake
- Recipes for over the counter supplements
- Recipes for prescribed supplements

Once you have carried out the MUST screening on your client there are documented action points to follow.

- If your client has a MUST score of 1 – the resource 'Handy hints to improve your nutritional intake' should be used to help your client increase their energy intake from food to promote weight gain.
- If your client has a MUST score of 2 – the resource 'Handy hints to improve your nutritional intake' should be used to help your client increase their energy intake from food to promote weight gain.

They may also benefit from the use of over the counter (OTC) supplement drinks / powder because they may not be able to consume enough energy from food alone, to improve their nutritional status. If you are advising your client to use OTC supplements the resource – 'Recipes for over the counter supplements' should be given, to aid compliance.

- If your client has a MUST score of 3 or above they are probably very malnourished or at severe nutritional risk – the resource 'Handy hints to improve your nutritional intake' should be used to help your client increase their energy intake from food, but they are also likely to need a prescribed nutritional supplement and a referral to the dietitian.

If the clients GP has already prescribed nutritional supplement drinks the resource – 'Recipes for prescribed supplements' should be given to aid compliance.

Handy Hints to Increase your Nutritional Intake

If you have a reduced appetite and/or have recently lost weight unintentionally, simple changes to how you eat and drink will help.

This leaflet aims to provide you with information and ideas to:

- Help ensure your food intake is as good as possible.
- To give you suggestions of meals, snacks and nourishing drinks for you to have until your appetite / weight improves.

Why have I lost my appetite?

You can lose your appetite for many reasons including illness or even side effects of medication. Sometimes it's hard to eat due to shortness of breath, or because you just don't feel like eating. Also it may be difficult for you to prepare food and therefore you have just started eating less.

Why have I lost weight?

You may have lost weight due to illness, or just because you haven't been eating as much as you need. The more weight you lose, the weaker you may feel and the less you may feel like eating.

By following the suggestions in this leaflet it will help you overcome these issues.

However, if you continue to have problems you should contact your GP, Practice/District Nurse or Community Matron.

Why is it important to keep eating?

What happens if I don't eat or eat very little?

After a few days without food, your body starts to use up fat and muscle to provide energy. This will make you feel weak and tired and perhaps make you feel even less like eating.

How can I eat enough when I don't feel like eating?

When you are finding it difficult to eat, the usual 'healthy eating advice' alone is not the right thing to do. You need foods that provide a lot of nourishment in small quantities (a good way is to add extra fat and sugar to your food), as well as eating a good variety of different foods.

How to maximise your Energy (Calorie) intake.

- Eating little and often is the best way to boost your energy intake, so supplement your main meals with in between meal snacks. This means you should try to eat every 2–3 hours during the day (however this can be difficult to do).
- Aim to eat protein rich foods at least 2–3 times per day, (e.g. Meat, fish, poultry, cheese, eggs, milk, peanut butter, nuts, peas, lentils and beans).
- The following foods are a good source of energy and need to be eaten with each meal: Breakfast cereals, porridge, bread, crackers, crisp bread, potatoes, rice, pasta but add margarine, enriched milk, cream or oil to further increase your energy intake.
- Do not use any diet or low fat foods

Hints and tips to improve your appetite

- If your appetite is better at certain times of the day, try and eat more then.
- Keep snacks that are ready to eat close to your chair, bed or in your pocket.
- Serve smaller portions of your meal on a large dinner plate to prevent feeling overwhelmed – you can always have more.
- Try ready-made meals, so they can be cooked quickly and do not take a lot of preparation
- Cook extra portions of meals in advance and freeze them for use another day.
- Try to make mealtimes a relaxed and positive experience, e.g. use background music, or try to eat with company.
- Have food and drinks separately, as drinking and eating at the same time will fill you up quickly.
- Avoid drinks that make you feel bloated (e.g. fizzy) as they can leave you feeling full.
- Eat a variety of foods that you enjoy.
- Try a small amount of alcohol before meals to stimulate your appetite, if permitted by your doctor.
- Try at least two nourishing drinks per day, e.g. milk, milky coffee, hot chocolate or malted drinks (see nourishing drinks ideas).
- If you are able to get outside, then gentle exercise and fresh air can help stimulate your appetite.

Nourishing drinks

Milkshake

- 1 glass (200 ml) fortified milk (see page 7 for recipe)
- 1 scoop ice cream
- 2 dessert spoons milkshake powder or syrup

Whisk all ingredients together until frothy and serve.

(For an alternative replace ice-cream with (50ml) plain yoghurt for a yoghurt style drink)

Fruit Smoothie

- 1 glass (200ml) full cream milk
- ½ small carton thick and creamy fruit yoghurt
- 1 scoop ice cream
- 1 teaspoon of honey
- Soft fruit of your choice

Mash the fruit with a fork. Mix all ingredients together, stir well or use a blender.

Fruity Float

- ½ glass (100ml) Fresh fruit juice
- ½ glass (100ml) Lemonade
- 1 table spoon sugar (15g) Sugar
- 1 scoop (60g) Ice Cream

Mix together with a fork/ whisk or blender and serve.

Enriched soup

- 1 packet of cup a soup
- 1 Mug (200ml) enriched full fat milk (warm)

Empty contents of packet into mug and add warm milk. Mix well.

Meal and Snack Ideas

Lighter options

- Sandwich filled with butter or mayonnaise and cold meat, bacon, tinned fish, cheese, egg or peanut butter
- Toast with butter and beans, cheese, ravioli, spaghetti, macaroni cheese, eggs or sardines
- Jacket potato with cheese, coleslaw, tinned fish or beans. Adding extra butter, margarine, mayonnaise or salad dressing will help to increase the calorie content further
- Soup with extra cream and bread with thickly spread butter or margarine
- Omelette with extra cheese and tomato.

Main meals

- Roasted, grilled, fried or casseroled meat with potatoes or chips, vegetables and a Yorkshire pudding
- Curry with rice, naan bread or chips
- Fish, fish fingers or fish in sauce with potatoes and peas
- Bacon, egg, beans and toast
- Lasagne, spaghetti bolognese or macaroni cheese
- Ready-made meals, e.g. shepherd's pie or fish pie
- Quiche, pizza or pork pie with coleslaw or potato salad.

Puddings

- Trifle – fruit or chocolate
- Egg custard
- Crème caramel
- Gateaux and cheesecake with cream or ice cream
- Full fat mousse
- Thick and creamy yoghurt
- Rice pudding with dried fruit, jam or honey
- Sponge and custard
- Ice cream with tinned fruit
- Instant pudding, e.g. Angel Delight
- Milky jelly made with evaporated milk or fortified milk

Useful snacks are

- Glass of milk and biscuit or cake
- Mixed nuts and dried fruit
- Individual desserts (e.g. crème caramel, full fat mousse, trifle)
- Full fat yoghurt
- Milk puddings
- Breakfast cereals
- 1 slice of bread sandwich with meat / egg / cheese filling
- Scone with Butter and jam (even cream if you wish)
- Packet of crisps
- Cereal Bar (e.g. Nutragrain, Tracker, Jordans)

If you are finding it difficult to eat normal / large meals or if you need to consume extra Energy, these suggestions will help.

This advice is about how to increase the Energy content of the food you eat, without you having to eat a large portion.

How to add extra Energy to the foods you already eat

- **Fortified milk** – To one pint of milk (ideally full fat but semi-skimmed would do) add 2oz (4 tablespoons) milk powder. Mix the powder to a paste with a little cold milk, then mix in the remainder.

Use the fortified milk in place of ordinary milk and aim for at least 1 pint per day. Also use in soups and sauces, casseroles, porridge, tea and coffee and on breakfast cereals.

- Make up **soups** with milk instead of water.
- **To soups and casseroles add:** grated cheese, cream, evaporated milk, dumplings, baked beans, pasta or milk powder (1 tablespoon).
- Add a sauce e.g. cheese **or white sauce** to fish or vegetables.
- **To potatoes and other vegetables add:** butter or margarine, cream, salad cream, fried onions, grated cheese or milk powder.
- Sprinkle grated cheese onto potatoes, vegetables, beans on toast and scrambled eggs.
- Add cream, evaporated milk or grated cheese to **milk based sauces**.
- Add double cream to **desserts, and fruit**.
- **To puddings add:** cream, custard, margarine, butter, evaporated milk, condensed milk, ice cream, jam, honey, syrup and dried fruit.
- Make **jelly or mousse** with fortified milk or evaporated milk instead of water.
- **To milk puddings add:** cream, evaporated milk or milk powder (1 tablespoon)
- Add jam, honey, syrup, peanut butter **to toast and crumpets**

- Choose **full fat products** wherever possible, rather than 'diet' foods, e.g. full fat cheese, condensed or creamy soups, 'thick and creamy' yoghurts and creamy puddings.
- **Use sugary foods** e.g. jam, syrup, honey and treacle on porridge, milk puddings, cakes and on bread.
- Add **extra sugar** in drinks, puddings, on cereals or porridge.

This advice can be confusing, because it is the exact opposite of the healthy eating advice that you hear so much about these days. At the moment though, your priority is to prevent further weight loss or possibly to gain some weight.

What if you need extra help?

If you are still finding it difficult to improve your appetite and weight with the information in this leaflet, there are nutritional supplements e.g. Complan available for purchase from supermarkets and chemists.

Complan: Original, Chocolate, Strawberry, Vanilla, Banana, Chicken

Complan & Oats (an alternative to porridge to provide you with extra nutrition)

If your chemist doesn't stock the savoury flavours, ask them to.

Please discuss this with your Practice / District Nurse, community matron or GP. They can also provide you with a recipe sheet for other ideas on how to use these products.

Are you worried about your cholesterol level?

Improving your appetite and / or re gaining the weight you have lost is important and takes priority. However, the advice in the booklet does encourage eating plenty of fat because it is a good source of Calories.

If you are concerned about your cholesterol level discuss this with your GP, because if you have lost weight your cholesterol level may have reduced.

Spreads high in mono-unsaturated fatty acids in particular (e.g. olive oil spreads, Bertolli) or polyunsaturated spreads (e.g. sunflower spread, flora) can be used instead of butter.

However, it is still recommended that you avoid the low fat varieties.

Sample meal plan

Breakfast:	Cereal with fortified milk and sugar Or / and Cooked breakfast, if desired, e.g. bacon, or sausage or egg and tomato Or / and Bread/toast with butter and jam
Mid-morning:	Glass of fortified milk or nourishing drink (see list). Small snack, e.g. biscuits, cake, crisps (see list)
Lunch:	Sandwich with meat, fish, cheese or egg. Or Creamy soup with bread and butter Or Toast with baked beans, egg, pate or fish. Puddings e.g. creamy yoghurt, ice cream (see puddings list)
Mid-afternoon:	As mid morning
Evening meal:	Meat, fish, cheese or egg Potatoes, rice or pasta. Vegetables or salad (with butter or mayonnaise) Pudding (see list)
Supper:	Hot milky drink with fortified milk, e.g. hot chocolate, Ovaltine or Horlicks Small snack (see list)

Recipes for using over the counter nutritional supplement: Complian

Fortified Soup (serves one)

- 3 tablespoons of Original Complian
- 1 packet instant packet soup (e.g. cup a soup)
- 200 ml (1 mug) full cream milk

Mix the soup mix with Complian.

Add a little cold milk to form a paste.

Boil the remaining milk and add slowly to paste. Stir well.

Fortified Savoury Sauce (serves one)

- 1 sachet Original Complian
- 1 carton of ready made sauce (e.g. cheese)

Make the sauce as directed on the packet.

Mix the Complian with a little cold milk to form a paste.

Slowly add the paste to the sauce and serve.

Fortified Cereal (serves one)

- 6 tablespoons instant cereal or 2 crushed Weetabix type cereal
- 1 cup full fat milk (150 ml)
- 3 tablespoons original Complian

Mix the Complian with the cereal.

Add the milk and stir well.

Add sugar, salt or fruit to taste.

Fortified Cheese Spread

- 2 heaped dessert spoons of Original Complian
- 2 oz (57g) full fat cheese spread

Mix the ingredients together to form a smooth paste, the spread on toast or add to potato.

Banana Custard

- 1 Sachet banana flavoured Complian
- 100 ml (6 tbsp) ready made custard
- 100 ml water

Mix the Complian and water together and stir into the custard. This could be served over a banana or add some chopped banana or other fruit.

Strawberries & Cream

- 1 sachet strawberry Complian
- 100 ml (½ glass) milk
- 50 ml (3 tbsp) single cream
- Strawberries

Mix the sachet of Complian with 100 ml milk.
Add up to 50 ml cream and stir with a fork.
Finish by adding chopped fresh straw berries.

Complan Breakfast

- Sachet of Complian & Oats
- 120 ml hot milk

Mix the ingredients together and add honey or sugar to taste

Black Forest Delight

- 1 Sachet of Chocolate Complian
- 1 pot of Cherry flavoured Yoghurt
- 100ml Water

Milk the Complian and water together and stir in the yoghurt.

Coffee Mocha

- 1 Sachet chocolate Complian
- 200ml Hot Water
- 1–2 teaspoons instant coffee

Mix the Complian with the hot water and add the coffee to taste.
You could also add cream.

Milkshake

- 1 sachet of Complian (flavoured)
- 200ml Full cream milk
- 1 scoop ice cream

Mix the ingredients together using a whisk or blender.
You could use Original Complian and add your favourite milkshake, flavoured powders and syrups.

Night-time drink

- 200ml Full cream Milk
- 1 tablespoon Original Complian
- 2 tablespoons of Horlicks / Ovaltine / Hot chocolate (sugar if required)

Mix the Complian with a little cold milk to form a paste.

Add the flavouring and hot milk.

You could top with marshmallows, chocolate flake or cream.

A guide to using your Prescribed Nutritional supplements

You have been prescribed Nutritional Supplements to complement your food intake as part of your treatment. It is important though that you continue to eat a varied and nourishing diet.

Nutritional supplements come in a variety of forms and flavours. There are also many different brands available.

Generally they can be broken down into 5 main categories:

- Milk shake style drinks
- Juice style drinks
- Semi – solid puddings
- Powders (that you make up with milk)
- Savoury drinks (Soups)

If you are struggling to take the supplement that you have been prescribed, please discuss this with your healthcare professional (e.g. GP, Nurse or Dietitian). It could be that you need to try a different type or flavour of supplement that would suit you better.

The majority of supplements come in sweet / fruity flavours but there are a few savoury ones available and please ask your healthcare professional about these. However in this booklet there are some useful recipes which incorporate the supplements into your meals, giving you a savoury option.

There are also starters or mixed packs available on prescription, which consists of milk and juice based supplements in the most popular flavours. These give you the opportunity to see which type and flavour supplement you prefer. However everyone is individual, so if it's not to your taste try a different one.

Hints and Tips

Supplements should be stored at in a cool, dry place (like you would store groceries) but are best served chilled, so store them in a fridge prior to serving.

Once opened they should be consumed within approx. 4 hours at room temperature, however can last for 24 hours once opened in a fridge.

Milk and juice based supplements can be frozen into lollies, sorbet/ice-cream.

Milk based supplements can be diluted with milk if you find them too sweet, but you will have to drink more volume.

Juice based supplements can be diluted with lemonade, squash, or juice but again you will have to drink more volume to consume the amount prescribed.

If alcohol is permitted, a small amount can be mixed with both milk and juice based supplements.

The supplements can be gently heated but do not allow them to boil, as this affects the nutrients and taste.

If fruity flavours are not to your taste try a coffee flavour or one of the savoury soups.

Neutral flavoured supplement can be used instead of milk in everyday drinks (e.g. in tea or coffee).

Avoid taking your supplement close to mealtimes as they are filling. In between meals and during the evening are good times to take them.

Recipes

A neutral milk based supplement can be used in any savoury dish as a replacement to milk (e.g. to make a white sauce), however always heat gently and do not boil.

Creamy Soup

1 small can of 'cream of 'soup (e.g. Cream of mushroom)

½ carton neutral milk supplement

- Heat the soup gently, mixing in the supplement.
- Remember not to boil the soup
- Serve with a swirl of cream or grated cheese.

Cheesy Scrambled Eggs

2 medium eggs

⅓ carton neutral milk based supplement

Butter or oil

40g (1 ½ oz) cheese

Seasoning

- Whisk the eggs, supplement and cheese together
- Heat the butter or oil in pan
- Add the egg mixture, heat gently and stir until the eggs are scrambled
- Season to taste

Creamy Sauce (ideal with pasta)

1 can of savour supplement (e.g. chicken)

1 tablespoon corn flour

- Mix the corn flour with a little water to form a paste
- Heat the supplement gently in a pan, add the corn flour and stir until sauce thickens.

Salad dressing / dip

2 tablespoon mayonnaise

1 tablespoon neutral milk based supplement

- Mix the ingredients together adding flavourings such as Garlic, Parmesan cheese, curry powder as required.
- Add to salads or as a dip with tortilla chips, breadsticks or vegetables

Mashed Potato

150g cooked potatoes

5g / 1 tsp butter (or to taste)

25ml Neutral flavour milk supplement

Salt and pepper to taste

- Place the mashed potato in a bowl.
- Mix in the butter and milk supplement.
- Add salt and pepper as required.

Porridge

40g / 1 ½ oz Porridge Oats (instant)

50ml (½ cup) whole milk

1 bottle of vanilla or neutral flavour milk supplement

- Place the porridge oats and milk into a pan and heat gently and stir continuously until a paste is formed.
- Stir in the supplement a little at a time to make a smooth porridge, warm gently (do not boil)
- Serve immediately adding sugar, salt, honey or fruit to taste

Scones (makes 8)

1 bottle of vanilla milk supplement
275g / 9oz Self-raising flour
50g / 2 oz butter
50g / 2 oz dried fruit
25g / 1 oz caster sugar
1 medium egg, beaten

- Sieve the flour into a bowl and add the sugar.
- Rub in the butter lightly using your fingers, until the mixture looks crumbly
- Add the dried fruit.
- Pour the supplement and beaten egg into the mixture and mix to form dough.
- Turn the dough out onto a lightly floured surface and roll out to about 2.5cm / 1 inch thick and cut out the scones.
- Bake in a preheated oven at 200C/ gas mark 7 for around 10 minutes or until risen and golden brown.

Serve with butter, jam and / or cream.

Rice Pudding

1 bottle of vanilla milk supplement
40g (1½ oz) pudding rice
275ml (a large mug) whole milk

- Bring the milk and rice to boil in a saucepan
- Reduce the heat and stir in the milk supplement
- Simmer gently (do not boil) for about 1 hour, stirring occasionally and adding extra milk as required.
- Once cooked serve with jam, honey, or fruit as required.

Jelly

1 carton of juice type supplement (flavour similar to the jelly)
1 packet of Jelly

- Dissolve the Jelly in boiling water as instructed on the packet
- Allow to cool a little (a few minutes) then mix in the juice based supplement.
- Make up with extra water as needed to make 570ml (1 pint) (Fruit could also be added if you wish).
- Separate into individual portions and leave in the fridge to set.
- Could be served with Cream or ice-cream

Alternatively use a milk based supplement to make a milk jelly.

Custard

1 carton of neutral milk based supplements
3 rounded tablespoons custard powder
A little milk

- Heat the milk supplement gently in a pan – do not boil
- Mix the custard powder with a little cold milk to form a paste
- Whisk the paste into the warmed supplements and cook over a low heat until thickened

Serve on its own, with fruit or your favourite sponge pudding

- As an **alternative** – flavoured supplements can be used to produce a flavoured custard (e.g. vanilla, strawberry, chocolate, banana)

Instant Whip

1 packet of instant whip powder
1 bottle of milk supplement (complementary flavour)
100ml (1 cup) whole milk

- Pour the supplement and milk into a bowl
- Add the instant whip powder and whisk
- Place the mixture into the fridge to set for about 5 minutes

Serve with fruit and cream if you wish

Smoothie

100g of fruit (your choice e.g. banana, strawberries, raspberries)
1 bottle of milk based supplement (flavour to complement fruit)

- Use a blender to puree the fruit.
- Whisk in the milk supplement and serve.

Add in a scoop (50g) Ice-cream for extra taste.

Yoghurt Drink

1 carton (125ml) flavoured yoghurt
½ bottle of milk supplement (your choice of flavour)

- Mix the two ingredients together to make a yoghurt style drink

Fruit Compote

1 bottle Juice style supplement (orange flavour)
150g mixed dried fruit, including apricots, dates and prunes
½ teaspoon ground cinnamon
2 tablespoons cream, to serve

- Simmer all the ingredients gently in a pot until the sauce thickens and the fruit softens
- Serve with cream

Produced by Isle of Wight NHS Dietitians
Last reviewed 2015

GULP feed assessment guide

Name IW/NHS number Date of birth

	Score 0	Score 1	Score 2
G auge 24 hour fluid intake	Intake greater than 1600ml	Unable to assess intake/intake between 1200ml and 1600ml	Intake less than 1200ml
U rine colour (Use pee chart)	Urine colour score 1–3	Unable to assess urine	Urine colour score 4–8
L ook for signs, symptoms and risk factor for dehydration	No signs of dehydration	If any below are reported <ul style="list-style-type: none"> Repeated UTI's Frequent falls Postural hypotension Dizziness/light-headedness Dry mouth/lips/eyes Taking diuretics Open or weeping wounds Hypoglycaemia 	If any below are reported <ul style="list-style-type: none"> Low blood pressure Weak pulse Sunken eyes Increased confusion or sudden change in mental state Diarrhoea and/or vomiting Fever
P lan	Low risk	Medium risk	High risk

Care plan – low risk of harm from dehydration	Care plan – medium risk of harm from dehydration	Care plan – high risk of harm from dehydration
Encourage service user to continue with current fluid intake Place keeping hydrated leaflet in patient file	Encourage service user to increase frequency or size of drinks – using 'Keeping Hydrated' leaflet for ideas Ask service user to self monitor urine colour and aim for urine colour 1–3	Ensure service user takes extra 4x250ml drinks per day (in addition to usual fluids and foods) by: <ul style="list-style-type: none"> Explaining guidance to family/carers Offer or encourage 250ml drinks at each visit Discuss 'Keeping Hydrated' leaflet with service user and or family/carers

Keeping hydrated leaflet to be used with GULP assessment guide

Keeping Hydrated

You should aim to drink at least 1.6 – 2 litres (2.8 – 3.5 pints), around 8 glasses, of fluid per day to stay hydrated. Drinking sufficient amounts can contribute towards staying fit and healthy. Signs of dehydration can include: a dry mouth or lips, thirst, tiredness, headache, dry and loose skin, and dark coloured or strong smelling urine.

Good levels of hydration in older people can help prevent or aid the treatment of:

Pressure ulcers
Constipation

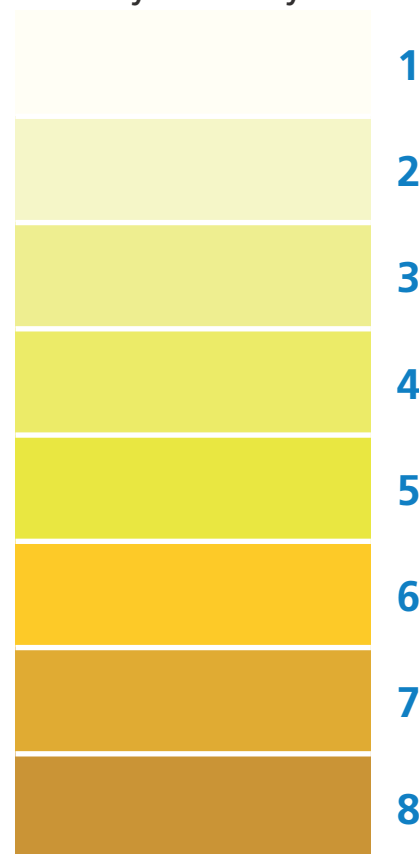
Low blood pressure
Confusion

Urinary infections
Falls

Hydration checklist

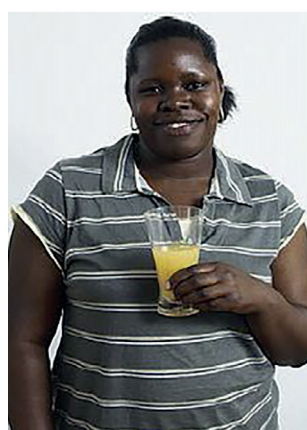
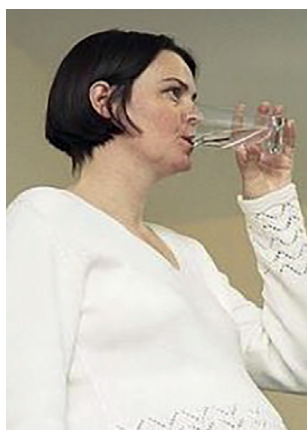
- Do you feel thirsty?** You may be already suffering from mild-moderate dehydration; thirst is often a late response to dehydration.
- Checking the colour of your urine is an easy way to assess your own hydration status:** use the pee chart to score your urine 1–8 to see if you need to drink more.
- Aging and illness can alter thirst response:** as you get older, you may not feel thirsty when you become dehydrated. This is also common in people who have had a stroke or suffer from dementia.
- Keep a close eye on your hydration status, especially in warmer conditions:** during summer months when the weather is hot, or inside the home when central heating is on, the fluid you lose through sweating will be much higher.
- You will sweat more if you are active:** try drinking at 10–15 minute intervals during exercise to prevent dehydration.
- If suffering from vomiting or diarrhoea,** you need to replace the fluid lost to prevent dehydration. Oral re-hydration salts are available at your chemist.
- If suffering from constipation,** drinking more fluid will help soften stools and make them easier to pass.
- Don't worry about urinating during the night:** try increasing your fluid intake earlier in the day. Aim to have a minimum of 600ml (1.1 pints) of fluid before lunchtime.

Healthy pee is 1–3 4–8 you must hydrate!



Top tips for healthy hydration

- Try drink fresh cool water:** fruit juice, milk, tea and coffee can also be taken. Opt for water, drinks that are sugar-free or skimmed milk if you have diabetes or you are trying to lose weight.
- Around 20% of our daily intake of fluid is contained within our food:** if you find it difficult to increase the amount you drink, try opting for foods high in moisture such as fruits and vegetables as these are up to 90% water.
- Semi-liquid foods count towards total fluid intake:** try soups, sauces, jellies, ice lollies and ice cream to increase fluid intake further. Chose sugar-free alternatives if you are diabetic or trying to lose weight.
- Nourishing drinks can also help increase calorie intake:** try making milkshakes, smoothies or hot chocolate made with full cream or fortified milk, especially if you are not eating well and need to maintain your weight.
- Avoid large amounts of caffeine and alcohol:** these can make you pass more urine and increase your risk of dehydration. Consume no more than 4 caffeine containing drinks per day. If you chose to drink alcohol, do so within line of current government guidance.
- Trying drinking in between meals or after eating:** avoid filling up on fluids before eating.
- Try to fit your fluid intake around your daily routine:** for example try having a full glass of water with medication(s), a glass of fruit juice after breakfast, a cup of tea mid-morning, squash after lunch, a smoothie or milkshake mid-afternoon, a cup of coffee after your evening meal, a glass of milk after supper, and a hot chocolate drink before bedtime.
- Tap water is safe to drink:** filtering water will freshen the taste slightly, however leaving water to stand can have the same effect. Adding some ice or chilling water will help to remove any chlorine taste.



A guide for the completion of the community SSKIN care bundle

The SSKIN Bundle is a bundle of care that involves fundamental components of pressure ulcer preventative interventions. It is crucial to remember that if only one of those components was to be omitted in the delivery of healthcare for patients at risk, the consequence is likely to be the development of a pressure ulcer.

The SSKIN Bundle will be completed for all patients identified to be at risk of developing a pressure ulcer, i.e. with a Waterlow score of 10 or more or deemed to be at risk by your clinical judgment.

- The patient will have a full skin assessment in conjunction with the Waterlow and this will be recorded on the Waterlow sheet.
- A registered practitioner will initiate the SSKIN Bundle and complete all the unshaded sections on the first sheet. This includes:
 - » Patient's name, NHS number and caseload and Waterlow score
 - » The specific mattress and cushion ordered and the date of the order, delivery and fitting
 - » The frequency of skin assessment based on your clinical judgement of the patient's need: daily/twice weekly/weekly/monthly/3 monthly
 - » The patient's current regime of movement in relation to when they get up or go back to bed or mobilise to the toilet
 - » The advice you have given to the patient and/or carer regarding repositioning
 - » The MUST score and date to review this
- The shaded areas are the specific components of the SSKIN Bundle that you are responsible for initiating.
- Any member of the healthcare / social team can complete the second page of the SSKIN Bundle. Only a registered and competent nurse can assess and grade pressure ulcers.
- If the patient is known to the district nursing service for 3/6/12 monthly interventions (including continence assessment) and is at risk of developing a pressure ulcer, the registered nurse will offer advice to the patient and/or carer and provide the Trust information booklet on preventing pressure ulcers. The advice will be recorded in the patient's records.
- If pressure relieving support surfaces are ordered at this point, a follow up visit will be arranged to evaluate the effectiveness of the support surfaces.
- If the patient is receiving healthcare from Intermediate Care, Crisis Response, Stroke Services or the Falls Prevention teams
 - » A Waterlow risk assessment will be carried out on the first visit.
 - » If this visit is not undertaken by a registered clinician, the assessment will be carried out by a competent healthcare worker.
 - » If the patient is found to be at risk of developing pressure ulcers, the healthcare worker will inform the registered clinician within the team of this risk.
 - » The registered clinician within the team will implement the SSKIN Bundle.
- If the patient is having additional support from care agencies, the registered clinician will perform the Waterlow assessment and initiate the SSKIN Bundle on first visit.
- If other agencies are involved please encourage them with support to complete the second page of the SSKIN bundle.

The community SSKIN bundle

Pressure ulcer prevention SSKIN bundle: community services

For all patients with a waterlow score of 10 or more (or at risk using clinical judgement): **implement a SSKIN bundle**

Patient's name	IW/NHS number	Locality	
Waterlow score	Date	Signature	Print name / Designation
Information plan given to patient/carer		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Prevention information booklet given to patient/carer		Yes <input type="checkbox"/>	No <input type="checkbox"/>
State all disciplines involved in care provision			

S	Surface
Provide a mattress and cushion in accordance with the Waterlow Risk Score and Equipment Flow Chart.	
Mattress ordered	Date ordered / Date delivered and fitted
Cushion ordered	Date ordered / Date delivered
Other (state item)	Date ordered / Date delivered
Wheelchair user? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, is a pressure reducing cushion in use in this? Yes <input type="checkbox"/> No <input type="checkbox"/>	

S	Skin inspection
Assess and record skin state on each visit (but no more than once a day). Carry out the skin tolerance test and observe for red patches of skin (erythema). Record the skin evaluation using the staging as follows and ensure location is recorded: No evidence of new pressure damage / Blanching erythema / Grade 1 / Grade 2 / Grade 3 / Grade 4	
Record frequency of skin assessment – circle one; daily / twice weekly / weekly / monthly / 3 monthly	

K	Keep moving
Record current regime of movement	
Morning	Afternoon
Evening	Night
Repositioning regime advised	
Method of transfer	

I	Incontinence
Assess continence state Assess if the patient's skin is prone to moisture	
Is the patient incontinent of urine Yes <input type="checkbox"/> No <input type="checkbox"/> Faeces Yes <input type="checkbox"/> No <input type="checkbox"/> Double Yes <input type="checkbox"/> No <input type="checkbox"/>	

N	Nutrition and Hydration
Ensure the MUST score is completed on the initial assessment and reassessment in line with MUST guidance	
Must score	Review date of MUST

Patient's name	IW/NHS number	Locality	
Date (DD/MM/YY)			
Time (use 24 hour clock)			

S	Surface						
Is the mattress in use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the cushion in use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is other (state) in use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the above equipment working effectively?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the patient comfortable	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
*if no to any of the above, please add additional information							

S	Skin inspection						
Is there evidence of pressure damage to							
B Buttocks (ischial bones)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
E Elbows	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
S Sacrum	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
T Trochanter (hips)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
S Spine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
H Heels	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
O Occiput	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
T Toes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other (please state)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
*if yes to any of the above, please add additional information							
If the patient declines skin inspection record reason and action taken in the box below							

K	Keep moving						
Is the current regime of movement being adhered to according to the patient/carer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the current regime effective	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
*if no to any of the above, please add additional information							

I	Incontinence/moisture						
Is the skin moist?							
Has the patient had a continence assessment?							
*if yes to the above, please add additional information							

N	Nutrition						
Is the patient eating and drinking adequately?							

Additional information – add any additional information required from your evaluation above						
S Support surface						
S Skin inspection						
K Keep moving						
I Incontinence/moisture						
N Nutrition						

A guide for the completion of the care home SSKIN bundle

The SSKIN Bundle is a bundle of care that involves five fundamental components of pressure ulcer preventative interventions. It is crucial to remember that if only one of those components was to be omitted in the delivery of healthcare for residents at risk, the consequence is likely to be the development of a pressure ulcer.

- Every resident will have a Waterlow risk assessment performed within 2 hours of admission and on transfer back from a hospital stay
- The resident will have a full skin assessment in conjunction with the Waterlow and this will be recorded on the Waterlow tool. If a pressure ulcer is identified (all Grades), a referral must be made to the District Nursing Team on the same day.
- The SSKIN Bundle will be completed for all residents identified to be at risk of developing a pressure ulcer, i.e. with a Waterlow score of 10 or more/deemed to be at risk by clinical judgement, for example, if the resident is not mobile.
- A new SSKIN Bundle will be completed each day.
- A Care Assistant who has undergone competency based training will perform the Waterlow assessment and initiate the SSKIN Bundle. On the SSKIN Bundle the Care Assistant will record:
 - » The resident's name, NHS Number and the name of the care home
 - » The Waterlow and if the patient is at risk
 - » The date of each day
 - » The Care Assistant's signature and name
- The shaded areas in grey identify each component of the SSKIN Bundle. This is the plan of care to prevent pressure ulcers from developing.

Surface

Provide a mattress and cushion in accordance with the risk assessment score and equipment flow chart. The type of mattress and cushion you provide is coded and this must be entered into the box stated "mattress in place and cushion in place". The resident's method of transfer will also be recorded here, for example; hoist, rotunda, assistance with one.

Skin evaluation

Assess and record skin state at least twice daily. Assessment of the resident's skin is coded. This will be recorded on the chart in the column headed Skin Evaluation. For example if, at 10am, the resident is repositioned the skin will be assessed at this time. If the resident has no new pressure damage the code SA will be recorded. If the patient is found to have new damage, the stage of the pressure ulcer will be coded and action taken will be recorded. For example, if a Grade 1 pressure ulcer is identified on the resident's sacrum, the code GR1 and sacrum will be recorded and action taken will then be recorded.

Keep moving

Record the repositioning regime and the frequency of repositioning for the resident in bed and sitting out of bed. This will be recorded in the box headed "REPOSITIONING REGIME" as per example on the SSKIN Bundle.

Record the code of position change. The various positions are coded and on each position change, the new position will be recorded against the time in the column headed Keep Moving. The frequency of repositioning must follow the stated plan.

Incontinence/moisture evaluation

Assess for moisture caused by urine, faeces, sweat or wound exudate. On repositioning or changing the resident's pad, the skin will be assessed for wetness and this will be coded in the column headed Incontinence/Moisture Evaluation. For example if the skin is found to be wet, the code I2 will be recorded along with the action taken.

Nutrition

Ensure a nutritional assessment is completed within 24 hours of admission and refer to the GP as necessary. Refer to dietician if the patient has a Grade 3/4 pressure ulcer.

The care home SSKIN bundle

SSKIN bundle – caring for your skin matters Pressure ulcer prevention for care homes

For all patients with a waterlow score of 10 or more: complete one form every day

Name	IW/NHS number	Care home
Waterlow score	At risk? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date
		Sign and print name

S	S	K	I	N
Surface	Skin evaluation	Keep moving	Incontinence	Nutrition
<p>Provide a mattress and cushion in accordance with the Risk Assessment Score and Equipment Flow Chart.</p> <p>Record the code in the box below;</p> <p>S1. Memory Foam mattress S2. Memory Foam cushion S3. Air cushion S4. Alternating overlay mattress S5. Alternating replacement mattress</p>	<p>Assess and record skin state at least twice daily.</p> <p>Carry out the skin tolerance test on red patches of skin</p> <p>Record the code in the skin evaluation and add location</p> <p>SA No evidence of pressure damage or blanching redness</p> <p>Gr1: Grade 1. Gr2: Grade 2. Gr 3: Grade 3. Gr 4: Grade 4.</p>	<p>Record the repositioning regime and the frequency of repositioning for the resident in bed and sitting out of bed</p> <p>Record the code of position change in the column below;</p> <p>K1. Left 30° tilt K2. Right 30° tilt K3. Left side K4. Right side K5. Back K6. Sitting up in bed K7. Sitting out K8. Standing for 2 mins K9. Helped to the toilet K10. Other: specify</p>	<p>Assess for moisture caused by urine, faeces, sweat or wound exudate.</p> <p>Record the code of skin moisture in the column below;</p> <p>I1. Skin is not moist I2. Skin is moist I3. Skin is excoriated I4. A moisture lesion is present</p>	<p>Ensure a nutritional assessment is completed within 24 hours of admission and refer to the dietician as per protocol.</p> <p>Refer to dietician if the patient has a Grade 3/4 pressure ulcer.</p>

Repositioning regime: Record the specific regime for this patient including the frequency of repositioning in bed and when sitting out. **For example; change position every 3 hours when in bed and do not sit out for longer than 2 hours.**

Surface: State type and code

Mattress in place

Cushion in place

Method of transfer

Name IW/NHS number Date of birth

Time	Skin evaluation, including location	Keep moving, position change	Incontinence/moisture evaluation	Actions taken/comments	Initials	Designation
Example	Gr1 left ischium 3x2cm	K9	I1	Cushion upgraded to repose air cushion. Matron informed.	PL	HCA
0900						
1000						
1100						
1200						
1300						
1400						
1500						
1600						
1700						
1800						
1900						
2000						
2100						

Name IW/NHS number Date of birth

Time	Skin evaluation, including location	Keep moving, position change	Incontinence/moisture evaluation	Actions taken/comments	Initials	Designation
Example	Gr1 left ischium 3x2cm	K9	I1	Cushion upgraded to repose air cushion. Matron informed.	PL	HCA
2200						
2300						
0000						
0100						
0200						
0300						
0400						
0500						
0600						
0700						
0800						
0900						

A guide for completion of the information plans

Information plans are tools that provide patients and carers with written information of the advice given by the clinician on all aspects of pressure ulcer prevention in conjunction with the Preventing Pressure Ulcers Information leaflet for patients. The tools aim to support the patient and /or carer to prevent pressure ulcers and also provide supporting evidence that advice has been given to them by the clinician.

There are two versions of the information plans

1. For giving to patients and carers (if appropriate) who are residing in their own home
2. For patients and their carers in a residential home

The information plans should:

- Record the advice given to the patient/carer
- Be clearly written and understood by the patient/carer
- Support patient engagement
- Be relevant and patient specific

Ensure the patient's name and NHS number is always recorded.

Ensure the patient's pressure ulcer risk is identified or if the patient currently has any pressure damage.

Record the type of pressure redistributing mattress and cushion that has been provided in the Care Home/ patient's home

Both versions of information plans are based on the concept of the SSKIN Bundle and are subdivided into the five sections which should include the following information, for example:

Surface

Record advice given on how the equipment you have provided should be maintained and/or how the pump works and that an electrical supply may be required at all times.

Include simple equipment checks, how to clean the equipment and who to report faults to.

Include what the equipment can/cannot be covered with and if it is appropriate to take pressure reducing cushions/ boots if the patient is going on outings or on holiday.

Skin

Record advice given on how the skin should be assessed and record that the clinician has demonstrated the skin tolerance test.

Identify specific aspects of the patient's skin that may be at risk and using the Pressure Ulcer Information leaflet, describe the visible signs of early tissue damage.

Record how often the skin should be assessed.

Keep moving

Record advice given on a realistic repositioning regime that has been agreed between the clinician and the patient / carer. Ensure the regime for day and night is clearly recorded, as this may vary. Recommend maximum times for the patient to sit out of bed.

Consider and allow for manual handling issues and what additional equipment is in use such as the rotunda frame, hoist or a sling.

Incontinence

Record continence management plans that are already in place.

Record advice given relating to cleansing and drying the skin and using the patient information booklet, describe the visible signs of a moisture lesion.

Record advice given in relation to toileting regimes use of emollients and barrier creams where appropriate.

Nutrition

Record nutritional advice given following the completion of the MUST plus GULP assessment tool. Consider discussing meal options and referring to the food first/ little and often leaflets. Include advice given from GP/ Dietician on SIP feeds /GULP tool if known.

Please ensure the patient / carer signs the plan, then give one copy to the patient / carer and file one copy in the patient's notes.

Community information plan for patients

Name of patient IW/NHS number

Further to our assessment you have been found to:

- Be at risk of developing a pressure ulcer
- You have developed a pressure ulcer which is close to the skin surface
(State location)
- You have developed a pressure ulcer which extends into the deeper tissues
(State location)

The following advice will help to reduce the risk of a pressure ulcer developing and help to heal the pressure ulcer you currently have and reduce the risk of it deteriorating.

S = Surface

A pressure relieving mattress and cushion will help relieve pressure.

K = Keep moving

Repositioning and movement will also help relieve pressure.

I = Incontinence

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

N = Nutrition

A balanced diet will assist healing and reduce the risk of pressure ulcer development.

If your dressing falls off it needs to be replaced with one supplied by the District/Community Nurse, and they should be contacted for advice.

Please contact Healthcare Team – Tel if you have any concerns.

This plan will be updated as appropriate.

Signature	Name of clinician	Date
Recipient signature	Print	Date

Patient information plan for care homes

Information plan for pressure ulcer prevention and management

Name of patient DOB

IW/NHS number Care home

(Tick as appropriate)

- Is at risk of developing pressure ulcers
- Has a superficial pressure ulcer (State location)
- Has a full thickness pressure ulcer (State location)

The following advice will reduce the risk of pressure ulcer development and assist any existing pressure damage to heal and reduce the risk of it deteriorating.

Please ensure the patient has the following pressure relieving equipment and it is used at all times:

Mattress Cushion

S = Surface

Please ensure the following skin inspection regime is followed.

K = Keep moving

Please ensure the following repositioning regime is followed.

I = Incontinence

Please ensure the following continence management regime is followed.

N = Nutrition

Please ensure the following dietary advice is followed.

If the patients dressing comes off please ensure the following occurs:

Please contact Healthcare Team – Tel if you have any concerns.

This plan will be updated as appropriate.

Signature	Name of clinician	Date
Recipient signature	Print	Date