OSKA™

CHANGING LIVES

THE 3C CONCEPT

Complete Pressure Care Toolkit

RESOURCES

Discover the new ideas in the care industry and learn about how they can improve the care you offer within your organisation.

TISSUE VIABILITY SUPPORT

Providing care can be demanding which is why our team are here to support you.

EDUCATION AND TRAINING

By understanding your patients' needs you can transform your care. Our courses help to give your staff the education and training they need.

OSKA are the pressure care experts. OSKA supplies innovative and world-renowned pressure care mattresses to aged care homes, hospitals, hospices and individual's homes in Europe and Australasia. The OSKA mattress is known as one of the best when it comes to pressure care that makes a difference to the lives of patients.

ASK OSKA™

Can I trial OSKA?

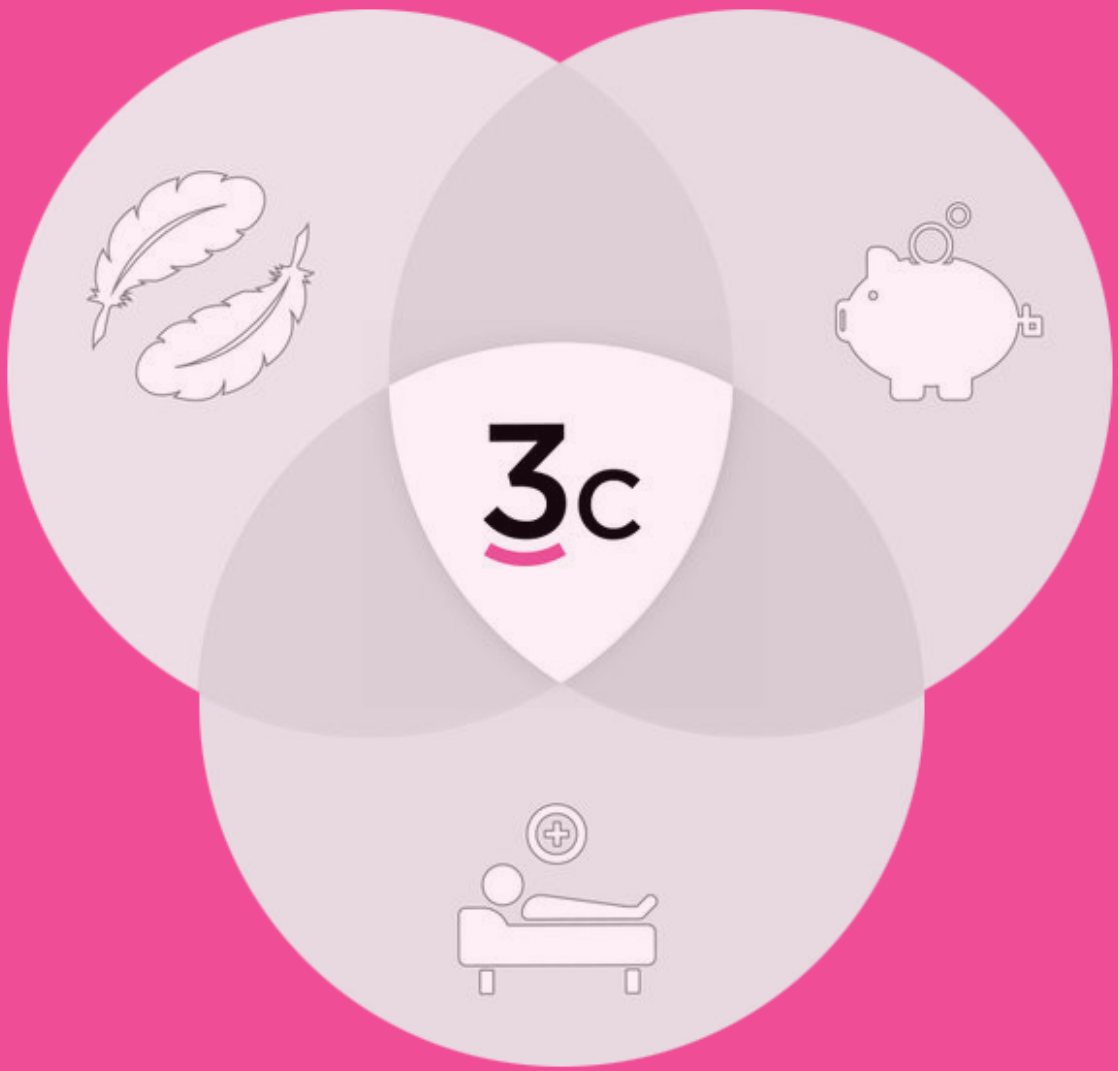
- Oska Pressure Relief Mattresses can be trialled from your local provider, contact us to facilitate this.

ask@oskacare.com.au

THE 3C CONCEPT

OSKA recognises everyone has different needs and preferences, especially when it comes to a mattress that has to provide a good night's sleep and prevent or treat pressure wounds.

Selecting a mattress is a balancing act between 3 key factors - Clinical, Comfort and Cost Effectiveness. Depending on the patient's condition, each of the factors hold a different level of importance.



CLINICAL

- Outstanding performance
- Prevention is better than cure
- Focus on shear and pressure reduction

COMFORT

- Patient comfort is paramount
- Ideal for palliative and dementia care
- Holistic care
- Eliminate non-compliance

COST

- Reduce use of expensive mattresses
- Reduce electricity, servicing and repair costs
- Reduce risk of litigation costs.

ASK OSKA

HOW CAN I CLINICALLY COMPARE PRESSURE RELIEF MATTRESSES?

THERE IS NO INTERNATIONAL STANDARD FOR PRESSURE RELIEF MATTRESSES HOWEVER OSKA HAS WORKED WITH FLINDERS UNIVERSITY TO CREATE THE GROUND WORK FOR THIS STARNDARD TO BE CREATED.

A new method of assessing the pressure distribution capability of mattresses has been devised using standard and commonly available test manikins and a commercially available interfacial pressure sensor.

A data analysis technique was developed that normalised the instantaneous pressure data against the known weight of the manikin to compensate for the absolute and drift error.

ask@oskacare.com.au

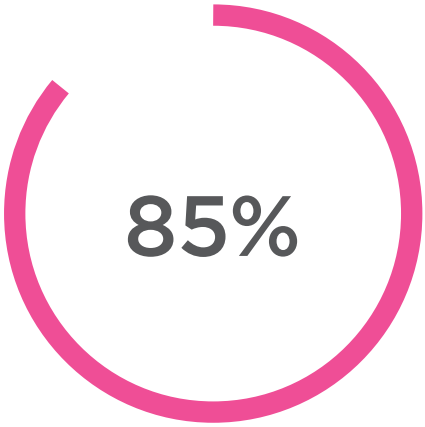
Flinders UNIVERSITY

MEDICAL DEVICE PARTNERING PROGRAM

About Pressure Ulcers

International NPUAP-EPUAP Pressure Ulcer Definition

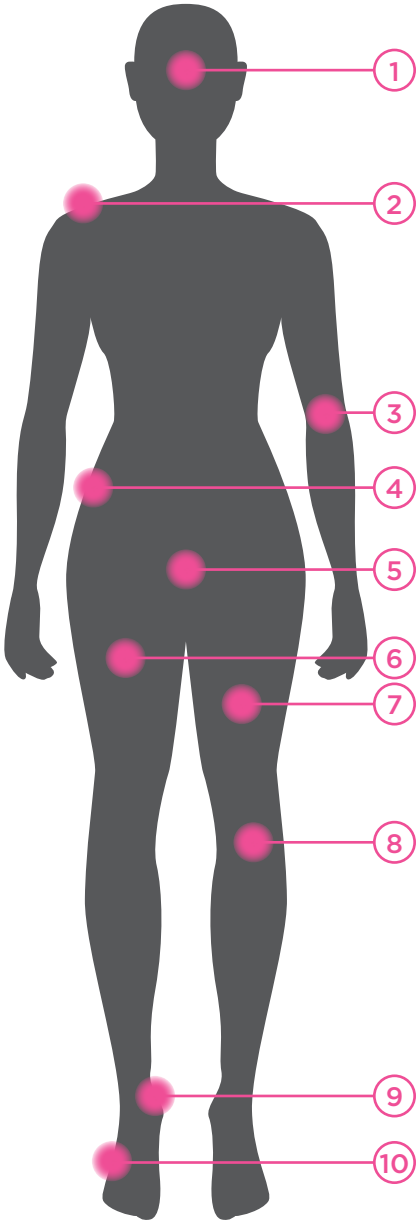
A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.



Percentage of pressure ulcers that could have been prevented.

Statistics suggest that 80-95% of pressure ulcers that occur on patients are avoidable. This means that you can help make a difference by preventing wounds from forming.

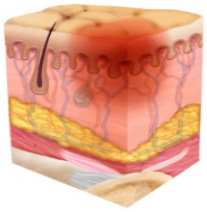
With the right equipment, knowledge and resource, we could decrease the number of pressure ulcers that plague our patients each year.



COMMON AREAS OF PRESSURE DAMAGE

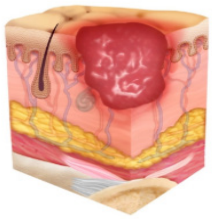
- HEAD 1
- SHOULDER 2
- ELBOW 3
- HIP 4
- TAILBONE 5
- BUTTOCK 6
- THIGH 7
- KNEE 8
- ANKLE 9
- HEEL 10

EPUAP/NPUAP Pressure Ulcer Categories



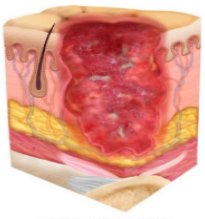
CATEGORY 1

Patients skin remains intact with a non-blanchable redness in a localised area. Pressure ulcers are commonly found over a bony prominence. Skin with dark pigmentations may not have visible blanching but, its colour may differ from surrounding areas.



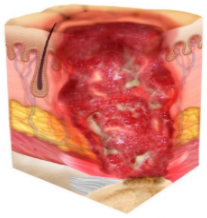
CATEGORY 2

Loss of dermis begins to become apparent with the wound bed being visible, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.



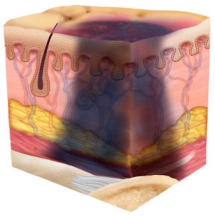
CATEGORY 3

Subcutaneous fat may be visible through full thickness loss of tissue. The tendons, bone or muscle are not exposed. You may see slough but it does not obscure the depth of tissue loss. Depending on the anatomical location, the depth of a category 3 pressure ulcer can vary. Undermining and tunneling may occur.



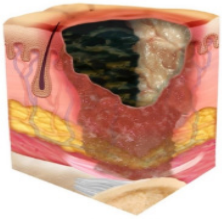
CATEGORY 4

The bone would be exposed with evidence of full thickness tissue being lost. It is most likely that you can see tendons and muscles. Slough may be present and can sometimes show signs of undermining or tunnelling. The depth can vary (depending on location).



DEEP TISSUE INJURY

The localised area presents with a maroon or purplish discoloration of intact skin or a blood-filled blister that forms due to shear and/or pressure. Prior to the identification of the discolored area, the skin may feel boggy, firm, mushy, painful, cooler or warmer than the surrounding skin. The wound may progress to a thin blister overlaying a dark wound bed.



UNSTAGEABLE

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a category 3 or category 4 pressure injury will be revealed.

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