Wirral University Teaching Hospital
NHS Foundation Trust

The SSKIN bundle is designed as a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers

S

A surface is classed as anything that will come into contact with the patient's skin.

For example chairs, cushions, beds, mattress, foot stools, medical devices and plaster casts.

• Patients who are assessed as at risk should be cared for on a pressure reducing or pressure relieving equipment.

• Pressure reducing equipment (for lower risk patients) is designed to distribute the body weight over a large as possible skin surface. For example foam, air or hybrid mattress.

• Pressure relieving equipment is designed to redistribute body weight periodically over different areas of the skin. For example cushions and air mattresses.

• At risk patients who are not bed bound should be assessed for a mattress and cushion.

• Ensure the staff members are aware of the different types of mattresses available.

• 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 seat cushion and replace with a pressure relieving cushion.

• Patients who are seated for long periods are at high risk of pressure damage. These patients will need repositioning even more frequently or standing periodically to allow a few minutes of tissue recovery.

• When seated, ensure patients back, legs and 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 or fixed deformities.

• Ensure staff are aware of which patients require the 30 degree tilt, and are competent in completing this task.

• Make sure mattress checks are completed daily, reviewing mattress integrity and checking inflation cells are not defective. If integrity is compromised or cells deflated the mattress will no longer be effective.

• Mattress to be cleaned daily, using the appropriate decontamination method as per Infection Control guidance.

• Ensure mattress pressure pumps are working and pressure is able to be adjusted accordingly if it is an air pump. Please contact equipment library if any issues.

S

• All patients require screening using the Braden Score at first contact.

• REMEMBER - Early inspection means early detection.

• Check the patient's skin to ensure it is not painful, discoloured or broken. This requires a full body map assessment and documentation on Cerner.

• Ensure Pressure Ulcer Plan (PUP) is implemented and senior staff is notified if any pressure damage is visible.

• Ensure incident forms are completed and referrals to the appropriate MDT are in place.

• Wound and skin conditions need to be accurately recorded, using wound measurements, and anatomical location is documented and clinical photography used when appropriate.

• The frequency of skin inspection should be completed daily and on each shift change.

• Skin inspections need to include the sites of any device interaction with skin.
For example oxygen tubing, orthopaedic appliances, medical devices, plaster casts, joint braces and supports.

• Please record any skin damage from appliances, devices and tubing.

• Any pressure damage identified will be based around EUPAP guidelines and local trust policies.

K

Assessing both the ability to walk and move (self or supported repositioning)

• The frequency of repositioning should be determined by patient's tissue tolerance, skin assessment and existing pressure damage.

• Encourage all patients to reposition as much as possible to relieve pressure.

• Transfer aids should be used to reduce friction and shear.

• Avoid repositioning over existing erythema, as this will cause more pressure damage.

• Patients with a category 3 or 4 sacral/buttock pressure damage ideally should not sit out, if this is essential for holistic care this should be around meal times only with a high risk pressure cushion in place.

• Repositioning should be influenced by the support surface and the patients risk status.

• If the patient requires Physiotherapy or Occupational Therapy , make sure a referral is completed.

• If the patient is non-compliant please document and report to senior nurse on duty.

• Ensure repositioning is documented on Cerner.

• Provide education to all patients with regards to repositioning if they are able to do so.

I

Having no or insufficient voluntary control over urination or defection.

• 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 may only be superficial but can be painful.

• The best treatment for prevention of moisture lesions is an effective barrier cream (Such as Derma S).

• The use of oily creams and those containing heavy metals (nappy type creams) are not recommended for use as they transfer to the pad and reduce its absorbency, leaving more moisture against the patients skin.

• Patient's skin that is already damaged is much more prone to pressure injury and skin breakdown.

• Skin needs to be washed using an appropriate PH cleanser (such as Dermol 500) as this will hydrate and maintain skin integrity, whilst providing antibacterial properties.

• Ensure skin is dry to prevent deterioration and potential fungal infections.

• Barrier creams should be applied in a downward motion to prevent friction and to provide protection.

• Ensure continence products including pads, convenes, catheters are applied correctly to reduce the risk of trauma and potential pressure damage.

• If the patient has a catheter please ensure the stat lock is applied to prevent trauma.

• Ensure no defects are present with continence products and if identified to discard and report immediately.

• Please assess the patient to see if continence products are required.

N

• All patients will be screened using the MUST tool at first presentation.

• If the patient requires support with meal times, ensure this is being provided.

• Ensure any diet requirements for the patient are requested.

• If the patient's appetite has diminished within the last 24 hours, a medical review will be required.

• Ensure any nutritional and fluid output charts are completed and documented on Cerner.

• If the patient requires a Dietician review, ensure the referral is completed.

• Please review if patient requires a high supplement diet

• If the patient's skin is dehydrated, they will be at risk of tissue break down. A medical review will be required.

• Ensure drinks are available for patients and that they can physically access refreshments.

• Any patients who are nil by mouth, ensure IV / Sub fluids have been prescribed to avoid dehydration.