# SKIN INTEGRITY

## Alert

### Pain and discomfort

**Wounds and pressure injuries can be extremely painful.**
**Good pain management, both pharmacological and non-pharmacological, is important**


## SKIN ASSESSMENT

## OBSERVE

### Look, listen, feel

- Colour changes
- Temperature changes - hotter or colder than surrounding skin
- Pain, sensitivity
- Swelling, oedema, blisters
- Lumps, bites
- Fragile skin
- Sweating, oozing, moisture
- Itching, rashes
- Bruises
- Odour
- Dryness, flaking, cracking
- Skin tears, broken skin, wounds and pressure injury

### CHECK

- Hair, ears, nose, mouth, breast, groin and all skin folds
- Feet, between toes, nails

# ACTION

## Action plan

### Care plan may include

See Pressure Injury Guide

### General skin care plan could include:

- frequent skin inspection
- keeping skin clean and dry
- use of PH friendly cleansers and soap substitutes
- use of moisturisers, barrier creams and prescribed creams
- resident wearing protective clothing, such as long sleeves, trousers, knee-high socks, skin protectors
- correct manual handling, regular position changes and use of sliding sheets and hoists when appropriate
- individualised continence management and appropriate toileting
- wound care
- appropriate equipment, such as pressure-relieving mattresses, appropriate seating and pressure-relieving devices
- good nutrition and fluid intake, may require food and fluid chart. Consideration of family/whānau involvement and personal preferences
- dietician input and supplements
- physiotherapy input and exercise plan
- soft well-fitting shoes
- pain management (including music, massage and repositioning

### Important considerations

- Undertake hand hygiene, as per infection control protocols
- Ensure clear documentation
- Involve resident and family/whānau
- Handle gently – avoid pulling or tugging of the skin, remove accessories such as rings, watches and so on
- Ensure safe use of equipment, such as sliding sheets, hoists and off-loading devices
- Avoid adhesive tape on fragile skin. If removing, do with care
- Ensure a safe, clutter-free environment
- Ensure ongoing updates and communication with registered nurse

## RECORD

**Document skin assessment, findings and interventions in progress notes and resident care plan.**

# PRESSURE INJURIES

## OBSERVE

### Look, listen, feel

- Erythema/redness (may look like a bruise/skin discolouration in residents with darker skin)
- Blanching response- no change in colour when skin is pressed (darker skin makes this more difficult to detect)
- Localised heat
- Microclimate, for example, sweating
- Oedema/swelling
- Skin breakdown/erythema on bony prominences, such as heels, ankles, bottom, tailbone, hips, elbows
- Skin breakdown under medical devices, for example, under indwelling catheters, oxygen masks and tubing
- Pain
- The darker the skin. the more difficult pressure injuries are to detect

**Be on the lookout for change in risk status**

## IDENTIFY

### Assessment

**Assess nutritional status – food and fluid, weight changes**

Check for general changes in health status:

- level of mobility
- exacerbation of chronic conditions
- bowel and urinary changes
- level of consciousness
- agitation
- behaviour changes
- mood
- shortness of breath and/or shortness of breath on exertion

# PRESSURE INJURIES

## ACTION

### Important considerations

- Clear documentation
- Family/whānau involvement. Involve and educate the individual and family/whānau about pressure injury risk and risk-reduction interventions
- Regular monitoring for change in condition
- Report changes early

**S** **Surface**
Make sure your residents have the right support

**S** **Skin inspection**
Early inspection means early detection. Show family/whānau, caregivers and colleagues what to look for

**K** **Keep** your residents moving and change position regularly

**I** **Incontinence/moisture**
Your residents need to be clean and dry

**N** **Nutrition/hydration**
Help residents to have the right diet and plenty of fluids

## RECORD

**Document in progress notes/update care plan**

# PRESSURE INJURIES

## RECORD

### ACTION PLAN

**Report to registered nurse with assessment. Initiate care plan. This may include the following.**

- Full head to toe skin check each shift including checking under medical devices and protective dressings, such as silicone foam dressings
- Avoid positioning on red areas or broken skin
- Use of pressure relieving devices and equipment, such as pressure-relieving mattress, heel protectors, cushions, sliding sheets
- Regular position changes. Choose frequency of turning based on support surface in use, tolerance of skin for pressure and individual preferences
- Consider lengthening position changes at night to promote uninterrupted sleep
- Encourage independence and mobility as much as possible
- Consider length of time sitting in chair
- Reposition immobile and weak residents in chairs hourly
- Discourage elevation of head above 30 degrees for more than one hour
- Manage continence. Cleanse skin promptly after episodes of incontinence
- Use substitute soaps
- Use barrier creams as required
- Moisturise skin daily
- Avoid rubbing fragile or reddened areas
- Ensure good nutrition and fluid intake. May require food and fluid chart. Consider assistance and support to increase oral intake, family/whānau involvement and personal preferences
- Give supplements as prescribed
- Pain management