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

IDENTIFY

SKIN ASSESSMENT

ACTION

REPORT

Report changes early to the registered nurse

Action plan

See the *Pressure Injuries* section of the *Skin Integrity Care Guide*

General skin care and tear prevention 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, which may require food and fluid chart. Consideration of family and 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
- Wound care as directed by the registered nurse

Important considerations

- Undertake hand hygiene, as per infection control protocols
- Ensure clear documentation
- **Report changes early to the registered nurse**
- Involve resident and family and whānau
- Handle gently – avoid pulling or tugging of the skin, remove accessories such as rings and watches
- 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 in progress notes and resident care plan

PRESSURE INJURIES

OBSERVE

Residents are at an increased risk for pressure injuries if they have a change in the following:

- 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 – a particular area of skin that is noticeably hot/warmer than other areas
- Oedema/swelling
- Skin breakdown/redness 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
- Depression

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
- Depression

PRESSURE INJURIES

ACTION

Important considerations

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

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

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

K **Keep** your residents moving and change position regularly, ensuring care is individualised

I **Incontinence/moisture**
Ensure your residents are clean, dry and toileted regularly

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

REPORT

Report changes immediately to the registered nurse

RECORD

Document in progress notes and 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 and whānau involvement and personal preferences
- Give supplements as prescribed
- Pain management