Community Standard Operating Procedure (SOP) 3 Pressure injury prevention: Very high risk

SKINS bundle

S is for Skin care
K is for Keep moving
I is for Incontinence/moisture management
N is for Nutrition
S is for Support surfaces

Frequency of reassessment:

- Immediately if condition deteriorates
- Skin inspections per clinical judgement
- Monthly if no pressure injuries

Prevention for very high risk patients incorporating SKINS bundle

Skin

1.1 All patients should have a risk assessment performed on initial contact visit. Assess the individual's skin condition and document in the nursing care plan.

1.2 Patients with pressure damage should have a skin inspection daily. This involves a visual inspection of all at risk areas especially over bony points and should be carried out by an individual who has been trained to inspect the patient's skin. This can include the patient or a formal or informal carer.

1.3 Patients with no recorded damage should have a skin inspection weekly or if condition changes. This can be performed by any individual who has been trained to inspect the patient's skin.

1.4 Patients in compression bandages, hosiery or ted stockings should have them removed at least weekly and heels inspected for damage.

1.5 Patients in compression bandages, hosiery or ted stockings, who are immobile and/ or have reduced sensation should have them removed at least three times weekly and heels inspected for damage for at least two weeks. The inspection can be done weekly afterwards if the heels remain without damage.

1.6 If a pressure injury is identified and you are unsure of the correct categorisation, visit the next day with a senior member of staff (Band 6 / 7 or a Tissue Viability Link Nurse) to reassess, categorise and Datix.

1.7 Individuals who refuse a skin inspection should be asked to identify areas of discomfort that could be attributed to pressure damage (verbal skin check see box 1, above).

BOX 1 Verbal Skin Check

1 Inform patient about pressure injury risk
2 Ask patient if they have any sore or painful areas and ask specifically about sore areas over bony points
3 Record results and document as a variance on the SOP.

See diagram on page four for full skin inspection guidance.

Keep moving

1.8 Educate patients at moderate risk, and no recorded damage to change position at least 2 hourly.

1.9 Educate patients with pressure damage to change position at least 2 hourly. If new damage presents with a 2 hourly regime educate the patient to change position hourly.

1.10 Involve carers and/or care agencies to move and turn patient if the patient has existing pressure damage and cannot move independently.

1.11 For individuals on bed rest consider reducing the risk of damage from pressure and shear by limiting head of bed elevation to 30 degrees and encouraging individuals to lie flat or at a 30 to 40 degree lying position if not contraindicated.

1.12 Reduce the risk of damage from friction and shear by using slide sheets when moving.

1.13 Patients with sacral pressure damage should limit time spent sitting in the chair to 1 hour at any one time.

Incontinence and moisture management

1.14 Assess the patients continence status.

1.15 Use barrier products appropriately.

1.16 Use incontinence aids as assessed as appropriate for the patient.

1.17 If the patient is incontinent of urine or faeces, balance the need for absorbency against skin damage and risk to the skin from exposure. Close fitting pad and pants should be used.

1.18 Patients with grade 3 and 4 pressure with copious urinary incontinence should be considered for a urinary catheter.

1.19 Keep the patient clean and dry at all times but do NOT rub the skin to get the circulation going as this will damage potentially already compromised tissues.

Nutrition

1.20 Complete the nutrition section of the Waterlow tool.

1.21 Identify all patient's nutritional risk on initial assessment and regularly thereafter, by completing the Malnutrition Universal Screening Tool *(MUST)*. Document MUST score.

1.22 Advise food fortification for all patients identified via MUST as medium or high nutritional risk.

1.23 Advise 2 high calorie/high protein snacks and/or milky drinks (not oral nutritional supplements) for all patients identified via MUST as medium or high nutritional risk .

1.24 Patients with grade 1 and 2 pressure injuries identified as medium or high nutritional risk, using MUST, should be referred to the dietician if this is also accompanied by two of more identified risk factors.

1.25 Patients with grade 3 and 4 pressure injuries and identified as medium or high nutritional risk using MUST should be referred to the dietician.

1.26 Monitor food and fluid intake, if any urgent concerns refer to the General Practitioner.

Support surface:
**** Refer to template for double and bariatric mattresses. Clinical judgement should be used when prescribing pressure relieving equipment.***

1.27 A patient at very high risk with no pressure damage may be able to remain on their own mattress providing they are able to reposition themselves. This should be closely monitored. A static air-filled mattress or castellated foam matress should be provided if close monitoring is not possible.

1.28 Patients, without pressure injuries and unable to change position independently should be provided with a high risk memory foam mattress replacement.

1.29 Patients with grade 1 and 2 pressure injuries who can move independently should be provided with a hybrid mattress or static air-filled mattress.

1.30 Patients with grade 1 and 2 pressure injuries who cannot move independently should be provided with a very high risk alternating cell mattress.

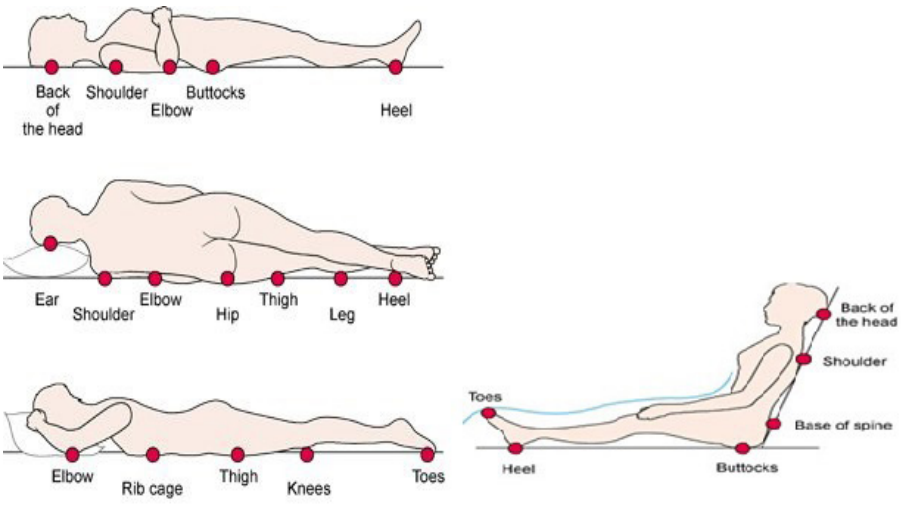
1.31 Patients with grade 3 and 4 pressure injuries who are able to move independently should be provided with a very high risk alternating cell mattress or hybrid mattress.

1.32 Patients with grade 3 and 4 pressure injuries who are unable to reposition themselves should be provided with a very high risk alternating cell mattress or hybrid mattress. These should be prescribed to be in situ on the day the injury is identified.

1.33 Prescribed equipment should be checked after delivery to ensure the devices supplied does not affect posture or the ability to transfer safely.

1.34 Patients with heel pressure damage should offload their heels. The choice of device will depend on risk factors and capacity to follow advice.

1.35 Patients at very high risk with accompanying neuropathy or foot deformity should be referred to podiatry.



- **A full skin inspection corresponds to observations of all bony prominances including their documentation.**
- **Variance - if unable to perform a full skin inspection document and give a rationale why.**

Taken from the patient information website of Cancer Research UK:
www.cancerresearchuk.org

Reassess:

Immediately if condition deteriorates

Skin inspections per clinical judgement

Monthly if no pressure injuries as minimum

Initial Assessment completed by:	
Patients Name:	
Date of Assessment:	
NHS Number:	
Waterlow score:	

Date	S = Skin	K = Keep Moving	I = Incontinence moisture	N = Nutrition	S = Support surface	Signature

Reassessment date: _____