Community Standard Operating Procedure (SOP) 1 Pressure Injury prevention: At 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 at 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 it in the nursing care plan.

1.2 Patients with pressure damage should have a skin inspection weekly. This includes 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 be educated in preventative measures and have skin inspected if condition deteriorates.

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

1.5 Individuals who refuse a skin inspection should be asked to identify areas of discomfort which could be attributed to pressure damage (see box 1, right).

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.

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

1.7 Educate patients at moderate risk, with no recorded damage, about the importance of repositioning themselves.

1.8 Educate patients with pressure damage to change position at least four hourly.

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

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

1.11 Patients with sacral pressure damage should alternate sitting in the chair and lying on the bed.

Incontinence and moisture management

1.12 Assess the patients continence status.

1.13 Use barrier products appropriately.

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

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

1.16 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

1.17 Complete the nutrition section of the Waterlow tool.

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

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

1.20 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.

1.21 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.

1.22 A patient at risk with no pressure damage can remain on their own mattress providing they are able to reposition themselves.

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

1.24 Patients with grade 1 and 2 pressure injuries who are unable to reposition themselves should be provided with a memory foam mattress replacement or static air-filled mattress.

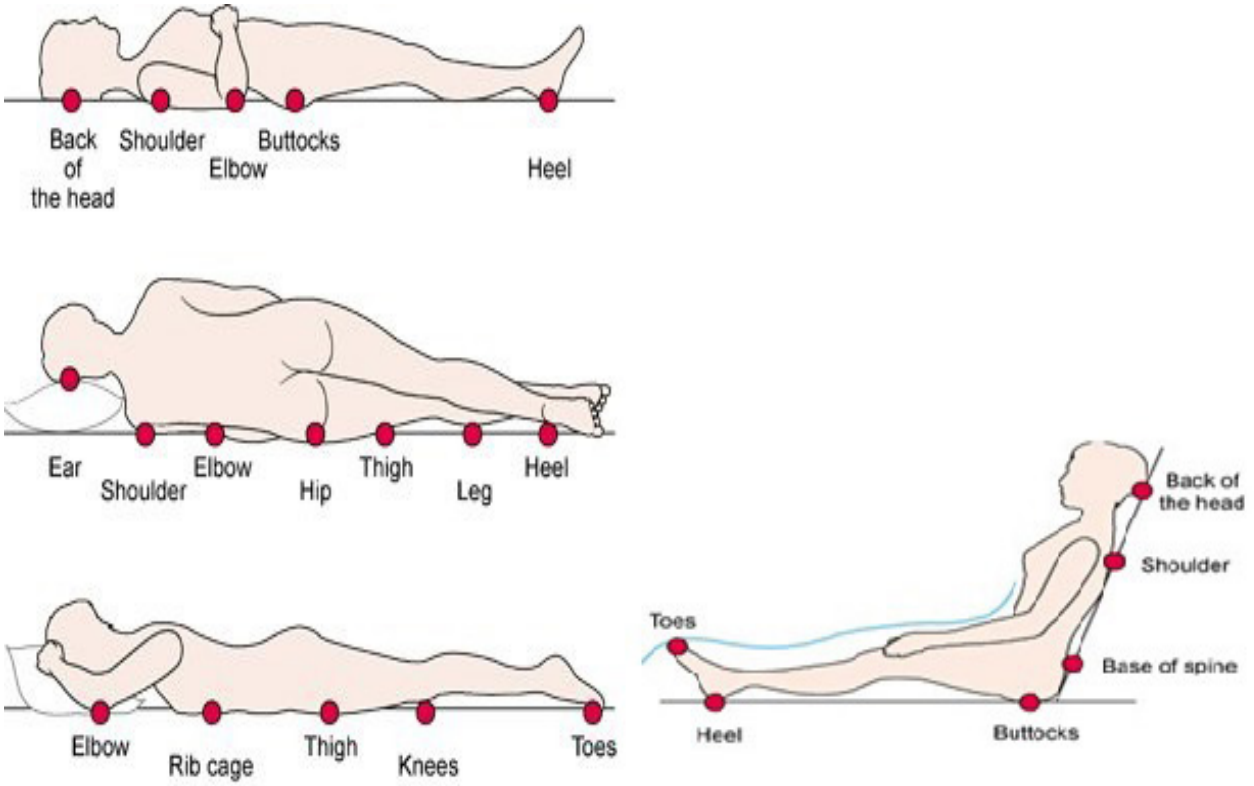
1.25 Patients with grade 3 and 4 pressure injuries who are able to move independently should be provided with a hybrid mattress or static air-filled mattress.

1.26 Patients with grade 3 and 4 pressure injuries who are unable to reposition themselves should be nursed on a high risk alternating cell mattress or a hybrid matress.

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

1.28 Patients with heel pressure injuries who are able to move independently may require heel pressure relief only.

1.29 Prescribed equipment should be checked after delivery to ensure the device prescribed does not compromise transfer or posture.



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

- **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.**

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: _____