Partnership working with Wolverhampton Care Home Association

NHS Wolverhampton Clinical Commissioning Group

The Royal Wolverhampton NHS Trust

REACT TO RISK- Stop Pressure Ulcers! (A)SSKIN(E) Checklist for Care Homes

ASSESSMENT	SURFACE	SKIN INSPECTION	KEEP MOVING	INCONTINENCE AND MOISTURE	NUTRITION AND HYDRATION	ESCALATE and COMMUNICATION
Assess Assess Assess **(A)SSKIN(E) is for life** Be aware of the residents' health, nutrition, continence, disability, medication, social and psychological needs Risk assess these needs Risk assess non concordance and ascertain reasons Early signs of deterioration • Breathing • Colour of skin • Pain • Mobility • Tired • Sweaty • Poor nutrition • Dehydrated • Behaviour • Skin marking • Infection • Weight loss	**Assess Surfaces** Pressure ulcer risk assessment. Foam redistribution surface for low – high risk mobile clients with normal skin, up to grade 2 Air mattress for high -very high immobile/ mobile clients with grade 2, 3 and 4 Document mode/ setting and check daily Check seat height/width Check devices i.e. • Glasses • hearing aid • stockings • oxygen devices • catheters	**Assess Skin** **Daily** full body check whilst washing/dressing/toileting and document Look for anything different ie, redness, discolouration, harder, softer, warmer, colder, pain, swelling, blisters or wounds. (Nursing homes- follow guide for wound assessment) Maintain dignity by completing skin assessment when attending to personal needs. Use pH balanced products to prevent dry skin. Pat skin dry. Moisturise dry skin Check all skin folds especially if patient is obese or has contractures. Use heel balms on dry heels particularly in diabetes.	**Assess Mobility** Use slide sheets under body & heels to reduce shear and friction. Use hoists if recommended. State types and sizes of slings with loop settings and positions under legs. Use 30 ^{o} tilt when on side. Passive exercises, moving legs, arms, hands through a normal range of movements and document. Reposition- start 2 hourly, check skin tolerance increase time only if skin does not mark- max 4 hourly. If out of bed stand/hoist/ walk for a minimum of 3 minutes. Use profiling beds to change position of client. Offload heels with pillows from knee to ankle or heel devices considering individual needs and risks	**Assess Continence** Toilet First approach. Follow continence assessment instructions If using pads- 1 pad only Fold length ways to form a channel. No soap Apply skin protectant cream or film, once every 3rd wash or more frequently if very wet. If catheter in use position tube safely to avoid pressure and bypassing. Empty bag regularly to prevent bag from being too heavy. Report bypassing catheters, loose stools and signs of dehydration to the nurse/GP. Record stool type according to the Bristol stool chart Prevent client being too hot and sweaty	**Assess Nutrition and Hydration** Weigh client at least monthly, increase if weight loss noted, as per the MUST. Ensure a balanced diet. Record expected fluid intake and monitor. Record food and fluid if intake is poor. Be aware of special diets ie diabetic/renal/ Crohns/coeliac. Be aware of restricted fluids- renal. Refer to dietician depending on risk assessment and MUST guide. Inform GP if intake is poor	**Assess the need to take action and escalate** Inform next shift of care plan and actions. Inform senior/GP of any medical, skin, psychological changes and deterioration. Listen to clients. Listen to reports from colleagues, GP or nurses and visitors. Plan individualised care. Include what could go wrong and actions to take. Tell patient or next of kin if there are any skin changes/ concerns. Tell Tissue viability Nurse (nursing homes) if any grade 3 or 4 pressure ulcers or non-healing wounds. Report any grade 3 or 4 pressure ulcer to CQC and safeguarding.
INCLUDE (A)SSKIN(E) PRINCIPLES IN YOUR PRESSURE ULCER PREVENTION CARE PLANS AS BELOW						
Record assessments	**Record on plan of care**	**Record frequency of skin assessments and wound assessments on plan of care**	**Record frequency of repositioning, exercise regime, and safe positions in plan of care**	**Record all continence care on plan of care**	**Record nutrition and hydration actions on plan of care**	**Record all communications and escalations. Reassess resident. Review all plans of care**