SSKIN Guide

S Surface

Pressure injury risk factors vary from person to person. Support surfaces are 'specialised devices for pressure redistribution designed for management of tissue loads, microclimate, and/or other therapeutic functions (i.e., any mattress, integrated bed system, mattress replacement, overlay, or seat cushion, or seat cushion overlay)'.

Support surfaces should be chosen on an individual basis, depending on the needs of the individual for pressure redistribution and other therapeutic functions. In all cases, the manufacturer's recommendations for use and maintenance should be followed. Standards also serve manufacturers as a product development guide and to enhance quality assurance.

Pressure redistributing support surfaces are designed to either increase the body surface area that comes in contact with the support surface (to reduce interface pressure), or to sequentially change the parts of the body that bear load, thus reducing the duration of loading at any given body area.

Consider the individual's need for pressure redistribution based on the following factors:

- level of immobility and inactivity
- need for microclimate control and shear reduction
- size and weight of the individual
- risk for development of new pressure injuries, and
- number, severity and location of existing pressure injuries.

Use a high specification reactive foam mattress rather than a non-high specification reactive foam mattress for all individuals assessed as being at risk for pressure injury development.

Use an active support surface (overlay or mattress) for individuals at higher risk of pressure injury development when frequent manual repositioning is not possible.

1. Ensure that the bed surface area is sufficiently wide to allow turning of the individual without contact with the bed rails.
2. For individuals with obesity, select a support surface with enhanced pressure redistribution, shear reduction and microclimate features.
3. Use a high specification reactive single layer foam mattress or overlay in preference to a foam mattress without high specification qualities for individuals at risk of developing pressure injuries.
4. Consider using a reactive air mattress or overlay for individuals at risk of developing pressure injuries.
5. Choose a support surface that is based on your local area policies
6. Consider the weight of the bed, the width of doors, the availability of uninterrupted electrical power and safe location for the pump/motor, including its ventilation. Plans should be in place for the contingency of power failure.

7. Examine the appropriateness and functionality of the support surface every time you work with the person.
8. Identify and prevent potential complications of support surface use. Proper selection and operation of support surfaces is the key to preventing complications.
9. Before use, verify that the support surface is being used within its functional life span.
10. Continue to reposition individuals placed on a pressure redistribution support surface.

    Repositioning is still required for pressure relief and comfort when a support surface is in use. However, the frequency of repositioning may alter because of using a support surface.

11. Choose positioning devices and incontinence pads, clothing and bed linen that are compatible with the support surface. Limit the amount of linen and pads placed on the bed.
12. Choose heel pressure relieving devices that best meet patient need, including consideration for mobility and safety issues.

If the person has a pressure injury

Wherever possible, do not position the individual on an existing pressure injury.

Consider replacing the mattress with an active support surface with additional features, such as alternating air, which will provide more effective pressure redistribution, shear reduction and microclimate control for the individual if he or she:

- cannot be positioned off the existing pressure injury
- has pressure injuries on two or more turning surfaces (e.g. the sacrum and trochanter) that limit turning options
- has a pressure injury that fails to heal or demonstrates injury deterioration despite appropriate comprehensive care
- 'bottoms out' (mattress collapses in the centre) on the existing support surface.

For individuals with, or at risk for, a pressure injury, consider using a pressure redistributing support surface during transit.

Transfer the individual off a spinal hardboard/ backboard as soon as feasible after admission to an acute care facility in consultation with a qualified health professional.

S Skin assessment

For all patients, conduct a comprehensive skin assessment and document findings:

- as soon as possible, but within eight hours of admission (or first visit in community settings)
- as part of every risk assessment
- ongoing based on the clinical setting and the individual's degree of risk
- prior to the individual's discharge.

Increase the frequency of skin assessments in response to any deterioration in overall condition.

Include the following factors in every skin assessment:

- skin temperature
- oedema, and
- change in tissue consistency in relation to surrounding tissue.

Focus on overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels.

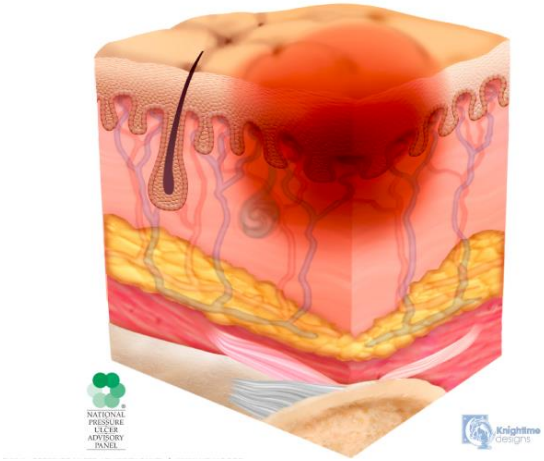
Each time the patient is repositioned there is an opportunity to conduct a brief skin assessment.

The skin of all patients should be checked daily in the acute setting.

Document all the findings of comprehensive skin assessments.

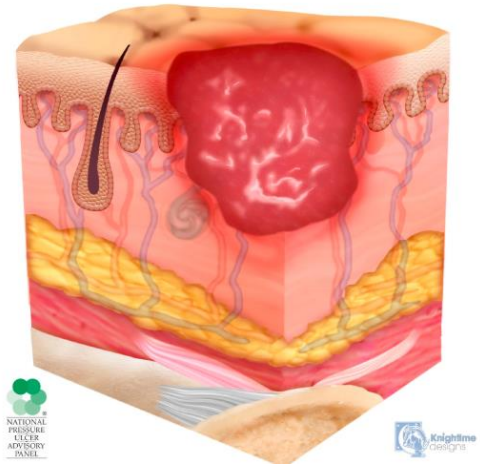
Implement a skin care regeime that is taylored to the needs of the individual patient.

Differentiate the cause and extent of erythema (redness). Differentiate whether the skin redness is blanchable or non-blanchable. Use a firm finger-pressure over the affected area for three seconds, then remove. If the area remains red (non-blanching) this is a stage one pressure injury. A stage one pressure injury will resolve if pressure is removed.



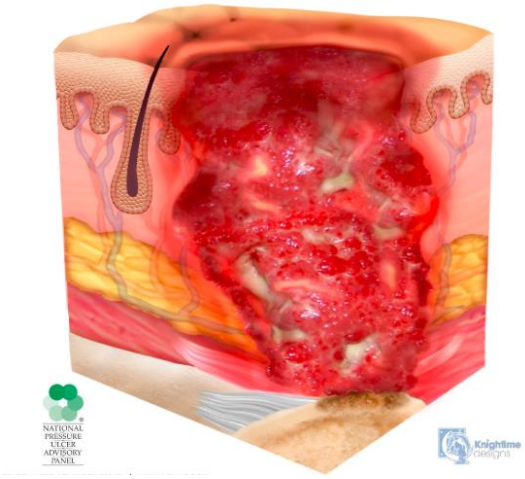
Stage 1 pressure injury: non-blanchable erythema

Intact skin with a localised area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Colour changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.



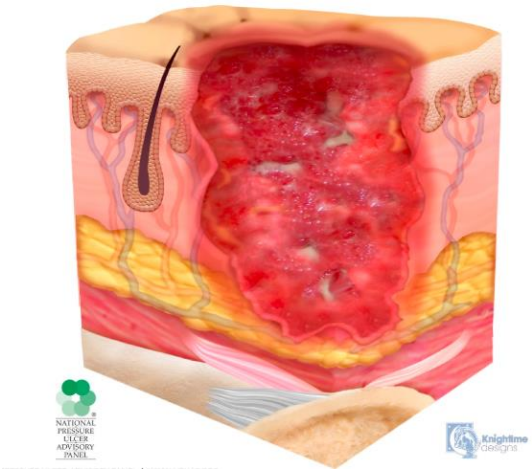
Stage 2 pressure injury: partial-thickness skin loss

The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough, and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture-associated skin damage (MASD), including incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical-adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).



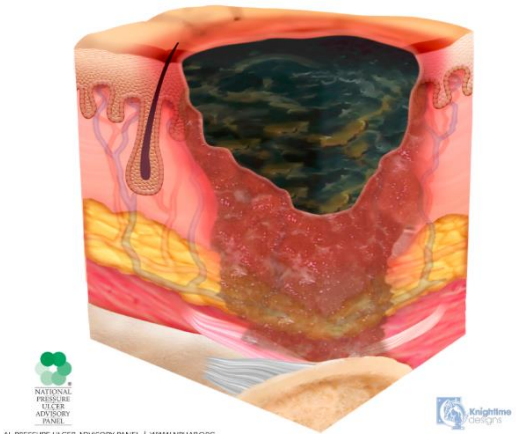
Stage 3 pressure injury: full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is not yet visible in the injury and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss, this is an suspected deep tissue injury.



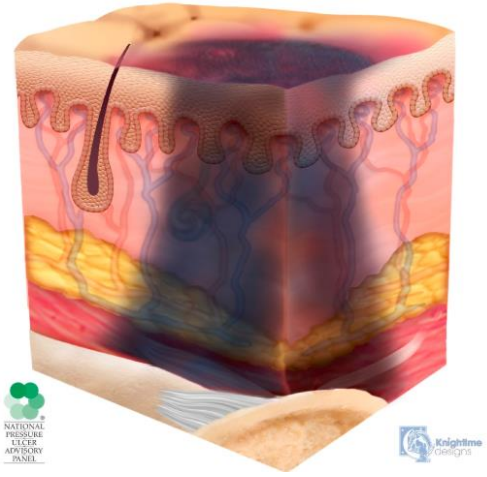
Stage 4 pressure injury: full-thickness tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the injury. Slough and/or eschar may be visible. Epibole (rolled edges), undermining, and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, this is an unstageable pressure injury.



Unstageable pressure injury: depth unknown

Full-thickness skin and tissue loss in which the extent of tissue damage within the injury cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a stage 3 or stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.



Suspected deep tissue injury: depth unknown

Intact or non-intact skin with localised area of persistent non-blanchable deep red, maroon, or purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (unstageable, stage 3, or stage 4). Do not use deep tissue pressure injury to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Seating

Inspect the skin for additional damage each time the individual is turned or repositioned. Do not turn the individual onto a body surface that is damaged or still reddened from a previous episode of pressure loading, especially if the area of redness does not blanch (i.e., Category/Stage I pressure injury).

Minimise seating time and consult a seating specialist if pressure injury worsens on the seating surface selected.

If sitting in a chair is necessary for individuals with pressure injury on the sacrum/coccyx or ischia, limit sitting to three times a day in periods of 60 minutes or less. Consult a seating specialist to prescribe an appropriate seating surface and/or positioning techniques to avoid or minimise pressure on the injury.

Select a seat and seating support surface that meets the individual's need for pressure redistribution with consideration to:

- Body size and configuration
- Effects of posture and deformity on pressure distribution
- Mobility and lifestyle needs.

Use a pressure redistribution cushion for preventing pressure injuries in people at high risk who are seated in a chair/wheelchair for prolonged periods, particularly if the individual is unable to perform pressure relieving manoeuvres.

Assess the relative benefits of using an alternating pressure air cushion for supporting pressure injury healing in individuals who are seated in a chair/wheelchair for prolonged periods, particularly if the individual is unable to perform pressure relieving manoeuvres.

Use a bariatric pressure redistribution cushion designed for individuals with obesity on seated surfaces.

The following 'devices' should not be used to elevate heels:

- synthetic sheepskin pads
- cut-out, ring or donut-type devices
- intravenous fluid bags
- water-filled gloves.

Medical devices

- Inspect the skin under and around medical devices at least twice daily for signs of pressure-related injury on the surrounding tissue.
- Consider using a prophylactic dressing beneath a medical device to reduce the risk of medical device related pressure injuries.
- Regularly monitor the tension of medical device securements and where possible seek the individual's self-assessment of comfort.
- Review and select medical devices with consideration to:
    - The device's ability to minimise tissue damage
    - Correct sizing/shape of the device for the individual
    - Ability to correctly apply the device according to manufacturer's instructions
- Conduct more frequent (greater than twice daily) skin assessments at the skin-device interface in individuals vulnerable to fluid shifts and/or exhibiting signs of localised or generalised oedema. This can cause a medical device that initially fits properly to exert external pressure to the skin.

K Keep moving

Repositioning of an individual is undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body and to contribute to comfort, hygiene, dignity and functional ability.

Consider the condition of the individual and the pressure redistribution support surface in use when deciding on a repositioning strategy. Regular positioning may not be possible for some individuals because of their medical condition, and an alternative prevention strategy such as providing a high-specification mattress or bed may need to be considered.

Determine repositioning frequency with consideration to the individual's:

- tissue tolerance
- level of activity and mobility
- general medical condition
- overall treatment objectives
- skin condition
- comfort.

Frequent assessment of the individual's skin condition will help to identify the early signs of pressure damage and, as such, their tolerance of the planned repositioning schedule.

If changes in skin condition should occur, the repositioning care plan needs to be re-evaluated.

Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved.

Avoid positioning the individual on bony prominences with existing non-blanchable erythema. Non-blanchable erythema is an indication of the early signs of pressure injury damage. If an individual is positioned directly onto bony prominences with pre-existing non-blanchable erythema, the pressure and/or shearing forces sustained will further occlude blood supply to the skin, thereby worsening the damage and resulting in more severe pressure ulceration.

Use manual handling aids to reduce friction and shear. Lift — don't drag — the individual while repositioning.

Use a split leg sling mechanical lift when available to transfer an individual into a wheelchair or bedside chair, when the individual needs total assistance to transfer. Remove the sling immediately after transfer.

Do not leave moving and handling equipment under the individual after use unless the equipment is specifically designed for this purpose. Avoid positioning the individual directly onto medical devices, such as tubes, drainage systems or other foreign objects.

I Incontinence and moisture

Develop and implement an individualised continence management plan.

Cleanse the skin promptly following episodes of incontinence. Use a pH balanced skin cleanser (a soap substitute).

Protect the skin from exposure to excessive moisture with a barrier product to reduce the risk of pressure damage.

It is important to note that skin damage from moisture is not a pressure injury, but the presence of skin damage from moisture may increase the risk of pressure injury.

Avoid vigorously rubbing skin that is at risk of pressure injury.

Use high absorbency incontinence products to protect the skin in individuals with or at risk of pressure injuries who have urinary incontinence.

N Nutrition

Screen nutritional status for each individual at risk of, or with, a pressure injury:

- at admission to a health care setting, or at first visit in community settings
- with each significant change of clinical condition and/or
- when progress toward pressure injury closure is not observed.
- At least every 7 days in the acute setting

Nutrition screening is the process used to identify individuals who require a comprehensive nutrition assessment due to characteristics that put them at potential nutritional risk. A dietician may complete nutrition screening.

Use a valid and reliable nutrition screening tool to determine nutritional risk.

Refer individuals screened to be at risk of malnutrition and individuals with an existing pressure injury to a registered dietitian, or an interprofessional nutrition team for a comprehensive nutrition assessment.

Nutrition assessment

1. Assess the weight status of each individual to determine weight history and identify significant weight loss (≥ 5% in 30 days or ≥ 10% in 180 days). What has the individual's diet been like prior to admission?
2. Assess the individual's ability to eat independently.
3. Assess the adequacy of total nutrient intake (i.e., food, fluid, oral supplements and enteral/parenteral feeds).

The focus of nutrition assessment should be on evaluating energy intake, unintended weight change and the effect of psychological stress or neuropsychological problems. Additionally, assessment should include a determination of the individual's caloric, protein and fluid requirements.

Care planning

1. Develop an individualised nutrition care plan for individuals with, or at risk, of a pressure injury.
2. Follow relevant and evidence-based guidelines on nutrition and hydration for individuals who exhibit nutritional risk and who are at risk of pressure injury or have an existing pressure injury.

Energy intake

1. Caloric needs are ideally met by a healthy diet; however, some individuals are unable or unwilling to consume an adequate diet. Overly restricted diets may make food unpalatable and unappealing, and therefore reduce intake.
2. Offer fortified foods and/or high calorie, high protein oral nutritional supplements between meals if nutritional requirements cannot be achieved by dietary intake. Oral nutritional supplements (ONS), enhanced foods and food fortifiers can be used to combat unintended weight loss and malnutrition.
3. Consider enteral or parenteral nutritional support when oral intake is inadequate. The risks and benefits of nutrition support should be discussed with the individual and caregivers very early on and should reflect the individual's preferences and goals for care.

Protein intake

1. Consult with a dietician for those patients with nutritional risk and pressure injury risk, if nutritional requirements cannot be achieved by dietary intake.
2. Consult with a dietician if your patient has a pressure injury Category/ Stage III or IV or multiple pressure injuries when nutritional requirements cannot be met with traditional high calorie and protein supplements.

Hydration

1. Fluid serves as the solvent for vitamins, minerals, glucose and other nutrients and transports nutrients and waste products through the body. Health professionals should monitor individuals' hydration status, checking for signs and symptoms of dehydration such as: changes in weight, skin turgor, urine output, elevated serum sodium, or calculated serum osmolality.
2. Provide and encourage adequate daily fluid intake for hydration for an individual at risk of, or with, a pressure injury. This must be consistent with the individual's comorbid conditions and goals. Consider additional fluid for individuals with dehydration, elevated temperature, vomiting, profuse sweating, diarrhoea, or heavily exuding wounds.

Vitamins and minerals

Provide/encourage individuals at risk of, or with a pressure injury, to consume a balanced diet that includes good sources of vitamins and minerals. This may include the need to have supplements.