Community Paediatric Therapies

Identification Label:

Name:………………………………………

DOB:………………………………………..

Hospital/NHS Number:……………………

SSKIN Inspection checklist

with Escalations

Hospital/ Patients Home/ Care Home.…………………

Ward…………………………………………………….

Glamorgan Scale Completed

|  |  |
| --- | --- |
| **Child/Young Person’s Problem** (please tick)CYP at risk of developing pressure damageCYP has existing pressure damage | **Aim of Care**To prevent pressure ulcer development To prevent deterioration of existing pressure ulcer and promote healing  |
| **Reassess risk of pressure ulcer development if there is a change in risk factors or clinical condition** |
| **Plan of Care** | SignatureDate/Time |

|  |  |  |
| --- | --- | --- |
| ***Surface / Equipment*** | * Review of current equipment provision
* Check equipment surface
* Check meeting postural need
* Check age and condition of item and fitness for purpose
 | Arrange Ax for new equipment |
| Place on review |
| Liaise with manufacturer |
| Order new parts |
|

|  |
| --- |
| **Skin Inspection** |

*Frequent assessment of the individual’s skin condition will help to identify the early signs of pressure damage* *Reports of pain/discomfort at a site of pressure may indicate deteriorating skin status**Escalate pressure damage as identified in pathway* | * Conversation with parents regarding and concerns or changes in relation to skin integrity
* Actual observation of key sites
* If site identified from conversation need to inspect site and clearly document sites looked at and integrity of skin at those sites
* Check skin for signs of pressure damage at repositioning or at hygiene /dressing interventions. Document results.
* Complete a wound assessment document if pressure ulcer present
* Ask if pain is felt over pressure points at each skin inspection
* Consider patients with medical devices, including orthosis, seating, standing etc. If safe to do so, inspect skin under the device at least daily/each community visit
* If a patient reports pain or altered sensation under a cast /splint or other device, if safe to do so, remove device to check the skin, or seek specialist advice
*
 | Concern identified- escalate via pathway |
| Concern identified- communicate with team lead |
| Review of positioning passport |
| No concerns identified- clear documentation of sites chekced |
| **If issue with skin integrity identified please provide overview here****Image result for Blank Human Outline** |
| **Keep Moving /Reposition***Repositioning of an individual is undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body* | * Conversation with parents regarding change of position
* Review of positioning passport and update as required
* Promote/encourage independent movement where possible
* Plan repositioning/offloading to meet individual patient need: **Enter Individual details below**
* Avoid positioning an individual directly on a pressure ulcer and any medical devices
* To assist in optimising mobility, activity and/or function if required, refer to:
 | On admission |
| Review |
| Review |
| Review |
| Physiotherapist | **N/A** | **Yes** | **Date Referred** |  |
| Occupational Therapist  | **N/A** | **Yes** | **Date Referred** |  |
| **Document Individual Keep Moving/Reposition Care needs:** |
| **Incontinence/Moisture****Management***The presence of skin damage from moisture may increase the risk of pressure ulceration* | * Use skin emollients to hydrate dry skin in order to reduce risk of skin damage.
* Use a barrier product to protect the skin from exposure to excessive moisture

Refer for specialist advice if current regime is not effective  | On admission |
| Review |
| Review |
| Review |
| **Document individualised Incontinence/Skin Care needs**  |
| **Nutrition /hydration***Malnutrition or under nutrition is a reversible risk factor for pressure ulcer development*  | * Use repositioning opportunities to encourage fluid and food intake
* Coordinate repositioning to optimise nutritional intake at meal times
* Refer to Dietician if indicated
 | On admission |
| Review |
| Review |
| Review |
|  **Document Individualised Nutrition /hydration Care needs:**  |
| **Patient Involvement***Well informed patients are better able to change behaviour, manage their own health and enhances concordance with treatment regimes* | * Encourage the patient, carers and their families to make informed decisions about their care.
* Provide and explain information, in an appropriate format on Pressure Ulcer Prevention. Date information/leaflet given Date :…………………..
* Where a patient with capacity has refused a particular intervention or piece of equipment, determine reason for refusal and aim to address/resolve where possible eg pain relief /offer reasonable alternatives in order to minimise their risk of pressure damage. This should be clearly documented in the patients’ medical record
 | On admission |
| Review: |
| Review: |
| Review: |
| **Document Individualised Patient Involvement Care Needs:** |

Version (3) Developed by: All Wales Tissue Viability Nursing Forum. Issued: October 2020