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 damage  CYP 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** | | Signature  Date/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](https://www.bing.com/images/search?view=detailV2&ccid=M6yRWIDJ&id=864B51F9892D5D4B55A52DEF12E81C2F773BC02A&thid=OIP.M6yRWIDJGH0qkKqFVwxQdwHaHa&mediaurl=https%3a%2f%2fwww.xfanzexpo.com%2fwp-content%2fuploads%2f2019%2f11%2ffree-human-body-outline-printable-download-free-clip-art-throughout-blank-body-map-template.jpg&cdnurl=https%3a%2f%2fth.bing.com%2fth%2fid%2fR33ac915880c9187d2a90aa85570c5077%3frik%3dKsA7dy8c6BLvLQ%26pid%3dImgRaw&exph=1528&expw=1528&q=Blank+Human+Outline&simid=608050924056022240&ck=8DB15BA7DFEB26D50067BE84FBD506C1&selectedIndex=11&adlt=strict&FORM=IRPRST)** | | | | | | |
| **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:** | | | | | | |

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