Caregivers have the greatest opportunity to look, find and report

**General**
Any changes in skin:
- Colour e.g. red, white, purple
- Hot or cold
- Dryness, leaking, moisture or sweaty
- Scaling or itching
- Bruises or rash
- Swellings, lumps, blisters or bites
- Moles and freckles
- Cracking or broken skin
- Unable to turn, move or walk

Check:
- Hair, ears, eyes, nose, mouth and nails
- Skin folds: breast and groin
- Feet: toes and nails

**PROMPT**
- Cleansing—hygiene to be individualised
- Hydrating—with effective moisturisation
- Replenishing—hydration and nutrition
- Protecting against injury—moving & handling

**Skin Care**
- Follow skin integrity assessment core plan e.g. Waterlow, Bradens and Norron
- Appropriate pressure relieving mattresses and seating
- Review hydration and nutrition

**Moving & Handling tips**
- Appropriate moving and handling such as:
  - Gentle hands
  - Lifting devices
  - Regular turns and positioning
  - Arm and leg protection
  - Safe use of equipment and in clean working order
  - Follow policy for “falls Prevention”

**New skin tear**
- Stop bleeding and clean
- Tissue alignment—edges together—strip if needed
- Assess and dress: pressure dressing, clean non-stick covering
- Review and re-assess 24—46 hours by RN

**SKIN CLOSURE STRIPS**
- Strip only required if there is a flap
- Do not put on with tension / force
- Strips stay intact until falling off

If removing strips carefully peel from the base upwards

**Wound care**

**Check the care plan**
1. Keep the dressing dry as needed
2. Remove dressing safely and gently
3. Report changes and progress
4. Change dressing promptly
5. Document

**Pressure Points Check each shift**

- Elbow
- Back of head and ears
- Shoulder
- Lower back and buttocks
- Heel

**Report to RN**

GRADE 1
Skin is not broken but is red or discoloured. The redness or change in colour does not fade within 30 minutes after pressure is removed.

GRADE 2
The epidermis (top layer) is broken creating a shallow, open sore. May or may not leak.

GRADE 3
Ulceration progresses beyond the dermis to subcutaneous tissue (2nd layer). Redness remains around edges. Hardening of tissue or leakage can occur.

GRADE 4
Ulceration progresses to deeper layers and can extend down to the bone. Usually lots of dead tissue and leakage occurs.

**Remember!!!**

**Standard precautions**
- Is the resident in isolation?
  - Shower the resident last
  - Top to toe hygiene
  - Gown and glove and mask
  - Dispose of linen correctly
  - Follow policy for cleaning equipment
  - Wash your hands

**Your own hand hygiene**

Wash hands for 15-20 seconds with soap and warm running water and dry thoroughly

OR
Alcohol rub for unsoiled hands

- Have the family been notified?
- What is the care giver follow up plan after reporting this to the RN?

**RECORD / REPORT / ACTION**