SKIN

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 care plan e.g. Waterlow, Bradens and Norton
- Appropriate pressure relieving mattress 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

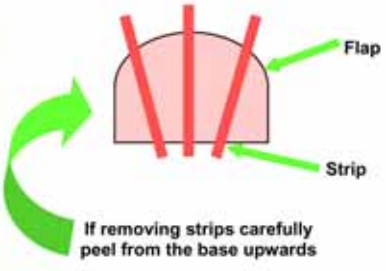
Assess and dress: pressure dressing, clean non stick covering

Review and re-assess 24—48 hours by RN

Document notes/handover, incident form and care plan

SKIN CLOSURE STRIPS

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



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

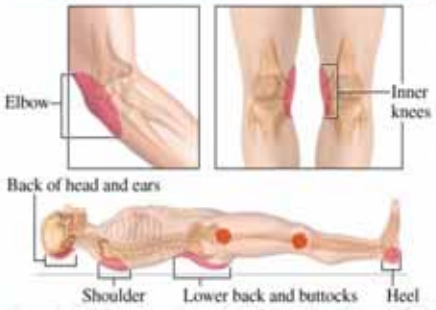
- Have the family been notified?
- What is the care giver follow up plan after reporting this to the RN?

Wound care

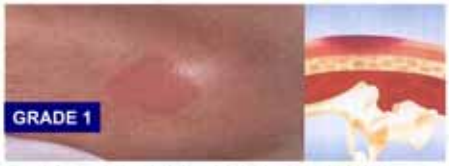
Check the care plan

1. Keep the dressing dry as needed
2. Remove dressing safely and gently
3. Report changes and progress
4. Replace the dressing promptly
5. Document

Pressure Points Check each shift

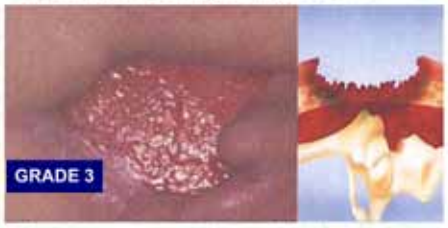


Report to RN

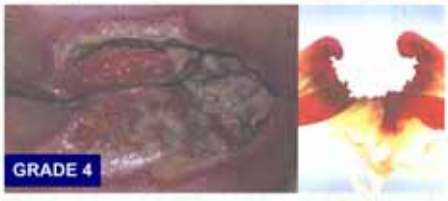


Skin is not broken but is red or discoloured. The redness or change in colour does not fade within 30 minutes after pressure is removed.

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



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



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

RECORD / REPORT / ACTION