Promoting Skin Integrity in End of Life Care

Part 2
Objectives

- To implement appropriate documentation/SSKIN Bundle
- To identify appropriate Pressure relieving equipment/strategies
- To be aware of the SCALE Principles
Code of Professional Conduct


10.4 “attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation”.
Risk Assessments

- WATERLOW
- MUST
Use of the SSKIN BUNDLE can prevent Pressure damage:

**S**: SUPPORT SURFACES.
**S**: SKIN INSPECTION.
**K**: KEEP MOVING.
**I**: INCONTINENCE ISSUES.
**N**: NUTRITION AND HYDRATION.
SSKIN BUNDLE

Surface

Mattress appropriate?

Cushion appropriate?

Checking equipment preforming.
Equipment selection
Don’t make your own!!
Mattresses: Alternating (Dynamic). Static (Foam)
A good sitting position is required to distribute body weight over the maximum surface area.
Cushions
Pressure Mapping

Before  Red areas high pressure

After Cushion redistributing the weight
Gel pads/bed cradles/ leg troughs
Skin Inspection

Checking for blanching
Skin Treatment.

- Keep the skin clean as it will reduce the risk of infection.
- Avoid too much washing or use of harsh soaps as they can dry the skin - use mild soap or oils.
- Remember moisturising protects the skin from drying.
## Intentional Care (rounding) / SSKIN Care Bundle

**Ward/Team:** __________

**Date:** __________

This patient requires Intentional care every __________ Minutes during the day __________ Minutes at night.

| Date: | Time: | 08:00 | 09:00 | 10:00 | 11:00 | 12:00 | 13:00 | 14:00 | 15:00 | 16:00 | 17:00 | 18:00 | 19:00 | 20:00 | 21:00 | 22:00 | 23:00 | 00:00 | 01:00 | 02:00 | 03:00 | 04:00 | 05:00 | 06:00 | 07:00 |
|-------|-------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| **Status** | | G=Oriented | M=Mildly confused | 5C=Severely confused | A=A-Asleep | Is the call bell within reach? | Y/N | Have you got any pain? | Y/N | Pain relief | Y/N | Environment safe? | Y/N |
| **Surface** | | Mattress working? | Y/N | Cushion appropriate? | Y/N | Functional integrity of equipment performed (lead, bed inflated etc.) | Y/N |
| **Skin Inspection** | | All pressure areas checked | Y/N | Blanching= B or Grade 1,2,3,4 | | | |
| **Keep Moving** | | | | | | Sitting out in chair | Y/N | Bed Rails | Y/N | N/A | Are bed rails down? | Y/N | N/A | Is the bed at lowest point to floor? | Y/N |
| **Incontinence** | | | | | | Urine | Y/N | Bowels | Y/N | Patient emptied | Y/N | N/A | Patient requires toileting | Y/N |
| **Nutrition** | | | | | | Food given | Y/N | Fluids given | Y/N | Supplements | Y/N | N/A | Is there anything else I can help you with? | |

If patient refuses, please place an R in the box. Any variance to care please document in patient’s notes. If pressure ulcer evident please ensure wound care plan is in place.

At the end of the 24 hour period/transfer or discharge please ensure this form is stored in the patient’s notes.

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**Affix Patient Id Label**

**Surname:** __________

**Forename:** __________

**NHS/Hospital Number:** __________

**Date of Birth:** __________

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**Barcode:**

**TSDFT 5125 2.0 11/16**
Intentional Rounding

• Rounding is a formal checklist used when checking on the patient.

• Specific questions are asked, answered and documented on the checklist.

• Rounding has been shown to reduce falls, dehydration, incontinence and pressure ulcer development.
Improvement over 24 hours................
by just moving!!
Total off loading of the heel is the only effective way to reduce the occurrence of heel ulcers.
Reducing Tissue Interface pressure/Sheer/Friction
SSKIN BUNDLE

Keep Moving

Seating

Lying

15 min
30 min

2 HOURS
Take the pressure off!!
Prevent friction by using a slide sheet
Moving and repositioning in bed

• Lying flat with minimum head elevation increases the surface area in contact with the mattress (Tissue Interface Pressure), reducing the load on the bony prominences.

• The knee break will support the full weight of the limb and allow for total off loading over heel.
30 degree tilt on one side is preferable to full turns side to side
SSKIN BUNDLE

Incontinence
Hydration

Fluid Intake is essential to provide nutrients and oxygen to the skin. It will also replace the fluid lost from breathing, sweating and urine.

As a guide a person should drink 1.2 litres of fluid per day.
SSKIN BUNDLE

Nutrition

8x 150ml glasses

The eatwell plate
Use the eatwell plate to help you get the balance right. It shows how much of what you eat should come from each food group.
Nutrition

• A balanced diet is important to retain skin integrity, especially adequate protein and vitamins and minerals.

• To increase a BMI add small amounts of extra food alongside a balanced diet:
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>CARE PLAN NO.</th>
<th>EVALUATION</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td></td>
<td></td>
<td>Support Surface-</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td></td>
<td></td>
<td>Skin Inspection-</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td></td>
<td></td>
<td>Keep Moving-</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td></td>
<td></td>
<td>Incontinence-</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
<td>Nutrition &amp; Hydration-</td>
<td></td>
</tr>
</tbody>
</table>

(S)=SUPPORT SURFACES (S)=SKIN INSPECTION (K)=KEEP MOVING (I)=INCONTINENCE (N)=NUTRITION & HYDRATION
# Wound Assessment Form

**Surnane:**
**Forename:**
**Hospital / NHS Number:**
**Date of Birth:**

**Ward/Team:** __________________________ **First Contact Date:** __________________________

<table>
<thead>
<tr>
<th>Date:</th>
<th>Site of wound(s):</th>
<th>Type of wound(s)</th>
<th>Please Circle:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Surgical</td>
<td>Pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leg Ulcer</td>
<td>Diabetic Foot</td>
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<tr>
<td></td>
<td></td>
<td>Other (please specify):</td>
<td></td>
</tr>
</tbody>
</table>

**General factors affecting health:****
- Diabetes
- Poor mobility
- Peripheral vascular disease
- Renal disease
- Cancer
- Concordance issues
- BMI < 20 or > 30
- Previous Stroke
- Previous MI
- Continence issues
- Other (please specify)

**Known allergies:**

<table>
<thead>
<tr>
<th>Referrals made by ward staff:</th>
<th>Vascular</th>
<th>Yes/No/Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastics</td>
<td>Yes/No/Needed</td>
<td></td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>Yes/No/Needed</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>Yes/No/Needed</td>
<td></td>
</tr>
</tbody>
</table>

**Other Healthcare Professional involvement (please delete as required):**
- Community Nurse / Podiatrist /
- Practice Nurse / Community Hospital /
- Acute Hospital.

**Description of wound bed and surrounding skin on first assessment:**
(to be assessed by a trained staff member, as per Trust policy):
Please number/document each wound.

**Pain:** None / at dressing change / intermittent / continuous
Score: 0-10 .......
**Wound swabbed:** Yes/No
If Yes, **Date:** .............................................
**Result (if available):** ...................................

Consent obtained to photograph wound:
- Verbal Yes/No
- Written Yes/No
- Wound traced Yes/No

**Signature:** __________________________ **Print:** __________________________
**Designation:** __________________________
**Date:** __________________________ **Time:** __________________________

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**TSDFT 5091 0.2 05/16**

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<table>
<thead>
<tr>
<th>Aid</th>
<th>Specify Type</th>
<th>Date</th>
<th>Aid</th>
<th>Specify Type</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Mattress</td>
<td>Dynamic Foam</td>
<td></td>
<td>Mattress</td>
<td>Dynamic Foam</td>
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<td>(Delete as required)</td>
<td></td>
<td></td>
<td>(Delete as required)</td>
<td></td>
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<tr>
<td>Basic/Intermediate/Critical</td>
<td></td>
<td></td>
<td>Basic/Intermediate/Critical</td>
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<tr>
<td>Bed frame</td>
<td>Bed frame</td>
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<td>Bed frame</td>
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</tr>
<tr>
<td>Heel/leg trough</td>
<td>Heel/leg trough</td>
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<td>Heel/leg trough</td>
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<tr>
<td>Cushion (Type)</td>
<td>Cushion</td>
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<td>Cushion (Type)</td>
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<td>Gel Pad</td>
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<td>Bed Cradle</td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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</table>

If wounds are present, please label them A, B, C etc. and indicate the position on the body outline.
# Wound Treatment Record

(To be completed at each dressing change/review)

<table>
<thead>
<tr>
<th>Week/Date/Time</th>
<th>Grade/site (A,B,C) etc</th>
<th>1) Wound bed description (%) 2) Wound measurement 3) Other factors (Infection etc.)</th>
<th>Treatment / Dressing chosen</th>
<th>Evaluation/rationale for treatment choice</th>
<th>Review Date</th>
<th>Signature/Print Name &amp; Designation</th>
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NB Trace/photograph wound weekly
SCALE Key Principles

1. Physiological changes that occur as a result of the dying process (Weeks to days) may affect the skin.
This may manifest as observable objective changes in skin colour, turgor or integrity or as subjective symptoms such as localised pain. These changes can be unavoidable and may occur despite the application of appropriate interventions that meet, or exceed the standard of care.
The plan of care and patient response should be clearly documented and reflected in the patient record.
The impact of interventions should be assessed, and revised, as appropriate.
Patient–centred concerns should be addressed, including pain and activities of daily living. A comprehensive, individualised, plan of care should not only address skin changes and any co–morbidities, but also any patient concerns that may impact upon quality of life, including physiological and emotional issues.
Skin changes at life's end (SCALE) are a reflection of compromised skin (reduced soft tissue perfusion, decreased tolerance to external insults and impaired removal of metabolic waste)
Expectations around the patient’s end of life goals and concerns should be communicated among the members of the multidisciplinary team and the patient’s circle of care. Any discussions should include the potential for SCALE including other skin changes, skin breakdown and pressure damage.
SCALE Key Principles

6.

Risk factors and symptoms associated with SCALE may include:

- Weakness
- Progressive limitation of mobility
- Suboptimal nutrition/loss of appetite
- Weight loss
- Cachexia
- Dehydration
SCALE Key Principles
6. (Cont.)

Risk factors and symptoms associated with SCALE may include;
- Diminished tissue perfusion
- Skin tears
- Impaired immune function
- Decreased skin temperature
There can also be loss of tissue integrity due to a number of factors including:

- Equipment/devices
- Continence issues
- Chemical irritants
- Extrinsic factors i.e. pressure, shear and/or friction
A total skin assessment should be performed regularly and areas of concern documented. This must be consistent with the wishes of the patient.
Consultation with a specialised healthcare professional is recommended for any skin changes associated with increased pain, signs of infection, skin breakdown (when the goal may be healing) and whenever the patients circle of care expresses a significant concern.
Pressure ulcer prevention is important for well being, enhanced quality of life and to avoid unplanned consequences for end of life care
Patients and concerned individuals should be informed regarding SCALE and the ongoing plan of care.
Remember NICE say’s

• DO NOT offer skin massage or rubbing: Think Shear & Friction.
• DO NOT offer nutritional supplements specifically to prevent a pressure ulcer in adults.
• DO NOT offer subcutaneous or intravenous fluids to prevent a pressure ulcer in adults who's hydration status is adequate.
Remember:

Life is tiring……after a whole day patients may not be able to move as readily as they can in the mornings!!
Remember:

Encourage regular movement but refrain from asking patients to move by digging their heels into the mattress or floor as this can cause tissue damage.
Remember:

Use a mirror to look at patients' heels, this saves a lot of bending and kneeling in awkward positions both for you and them!
Remember:
Patients should be positioned with their heels hanging over the end of a stool to achieve zero pressure.
References

- http://npuap.org
- http://www.nice.org.uk/guidance/cg179
- http://www.stop the pressure.co.uk


• http://www.kennedyterminalulcer.com/
Any Questions?