Standard Operating Procedure 1 (SOP 1)

SSKIN Assessment

**Why** we have a procedure?

All patients who have been identified as ‘at risk’ of developing a pressure ulcer, have an active pressure ulcer or are unable to re-position themselves independently should have a documented skin inspection. This Standard Operating Procedure (SOP) describes the use of the SSKIN tool including what to look for when carrying out a SSKIN inspection and when and how to escalate a potential risk.

**What** overarching policy the procedure links to?

Policy for the Prevention and Management of Pressure Ulcers

**Which** services of the trust does this apply to? **Where** is it in operation?

<table>
<thead>
<tr>
<th>Group</th>
<th>Inpatients</th>
<th>Community</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td>✓</td>
<td></td>
<td>all</td>
</tr>
<tr>
<td>Learning Disabilities Services</td>
<td>✓</td>
<td></td>
<td>all</td>
</tr>
<tr>
<td>Children and Young People Services</td>
<td></td>
<td>✓</td>
<td>all</td>
</tr>
</tbody>
</table>

**Who** does the procedure apply to?

This SOP should be used by all clinical staff including qualified and non qualified nurses, Occupational Therapists and Physiotherapists working within an inpatient unit within BCPFT.

**When** should the procedure be applied?

This should be carried out as part of a holistic assessment when a patient:

- Has been identified as ‘at risk’ of developing a pressure ulcer
- Has an active pressure ulcer
- Is unable to re-position themselves independently

**How** to carry out this procedure

**SSKIN Assessment Tool**

1. The SSKIN tool should be commenced on an inpatient who:
   - Has a Waterlow Score of 10+ (At risk)
   - Has an existing pressure ulcer
   - Is unable to re-position themselves independently

2. The SSKIN assessment tool should be carried out according to individual patient need. This can be 2 hourly, 4 hourly, each shift or daily. The decision is according to clinical judgement and must be multidisciplinary
3. All elements of the SSKIN tool must be completed and signed. Further guidance can be found in Appendix 1

4. Skin inspections should centre on those areas identified as most at risk for the patient (Appendix 2). These are commonly the heels, hips, buttocks, sacrum and between the knees. Children are also highly susceptible to ulcers on the occiput where they have difficulty supporting the weight of their head. Other areas may be affected depending on the patient's individual circumstances i.e. toes, ears, spine, shoulders, back of head

5. Any changes or inability to provide care (i.e. patient refuses) must be recorded in the nursing documentation.

6. All SSKIN assessment tool documentation must be filed in the patient's notes.

7. SSKIN must form part of the individual Pressure Ulcer Prevention and Management Care Plan.

8. The patient will remain on the SSKIN assessment tool as long as their Waterlow score is above 10, they have an active pressure ulcer or are unable to mobilise independently.

9. The SSKIN assessment tool should be discussed with relatives and supported by the Prevention and Management of Pressure Ulcers Patient and Carer Information Leaflet (Appendix 3).
### Appendix 1 - SSkin Pressure Area Prevention Bundle

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Waterlow Score:</th>
<th>Frequency of Assessment: (please circle)</th>
<th>2hrly, 4hrly, each shift, daily</th>
</tr>
</thead>
</table>

**SURFACE**

<table>
<thead>
<tr>
<th>Mattress</th>
<th>Inflation/alarms checked</th>
<th>Chair cushion</th>
<th>Heel protection</th>
</tr>
</thead>
</table>

**SKIN CONDITION:**  
A = normal, B = red and blanching, C = non-blanching red/purple, D = blister broken, E = black, F = covered by dressing, G = grade of PU

<table>
<thead>
<tr>
<th>Left heel</th>
<th>Right heel</th>
<th>Sacrum</th>
<th>Buttocks</th>
<th>Other</th>
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</thead>
</table>

**KEEP MOVING:**


**INCONTINENCE**

<table>
<thead>
<tr>
<th>Skin wet (Yes/No)</th>
<th>Urine</th>
<th>Bowels</th>
<th>Barrier product</th>
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</thead>
</table>

**NUTRITION**

<table>
<thead>
<tr>
<th>Diet type</th>
<th>Oral fluids taken</th>
<th>Other</th>
<th>Signature/initials</th>
</tr>
</thead>
</table>

SURFACE

- Select correct mattress and cushion according to equipment selection flowchart
- If at risk of heel ulcers – heels should be free from the bed surface at all times either by means of a pillow under the calves or a pressure offloading device...

**Diabetes + Neuropathy + Immobility = High Risk**

- check air-mattress/cushion and power box for faults at each positioning
- Do not use multiple layers under the patient – keep sheet free of wrinkles, ensure top sheet not tight over the feet
- Be sure patient is not lying/sitting on tubing. If patient is receiving oxygen, ensure ears/nose are assessed
- Reassess pressure ulcer risk (Waterlow) weekly as a minimum

KEEP MOVING

- Assess both ability to walk and ability to move
- Assess movement requirements when sitting in a chair as well as when lying on a mattress
- Reposition patient every [ ] hours in bed and every [ ] hours in chair (minimum 4 hours in bed/ 2 hours in chair). Encourage mobility.
- Inspect skin and document at every position change or once every 24 hours if patient moves unaided
- Devices to assist manual handling (e.g. slide sheets; hoists) should be used to reduce the potential skin damage to the patient or injury to carers
- Report any deterioration in patient’s skin to nurse in charge and re-evaluate prevention strategies

INCONTINENCE

- Offer toileting assistance regularly according to individual need
- For patients with incontinence, use well-fitting continence products. Wash and dry skin when soiled – use soap-free products
- **DO NOT** use oil-based creams (e.g. Sudocrem) with continence products
- Consider barrier products for use in the incontinent patient

NUTRITION

- Complete MUST tool and follow recommendations ensuring optimal nutritional intake
- Monitor intake of food and fluids
- Give support at mealtimes
- Utilise fortified supplements where appropriate
Appendix 2 - Areas of the Body at Risk of Developing Pressure Sores

1. Sitting

![Diagram showing areas of the body at risk of pressure sores when sitting]

2. Lying

![Diagram showing the areas of the body at risk of pressure sores when lying down]
Appendix 3

Look for signs of damage: Check your skin for pressure damage at least once a day. Look for skin that doesn’t go back to its normal colour after you have taken your weight off it. Do not continue to lie on skin that is redder or darker than usual. Check for blisters, dry patches and cracks in the skin.

Protect your skin: wash your skin every day using a mild soap and warm water. If you suffer from incontinence please inform your health care team as they can provide pads and barrier preparations to prevent soreness.

Eat a well-balanced diet: make sure you eat a healthy balanced diet and drink plenty of fluids.

What to do if you develop a pressure ulcer or think you are at risk:
- Tell your doctor or nurse as soon as possible and follow the advice they give you
- Your health care team will assess your general health which will help them establish if you are at risk of pressure damage. If necessary, the relevant preventative care will be planned. This may involve the use of a specialised mattress for your bed and a pressure relieving cushion for when you sit in a chair.

Advice and support
We hope that this leaflet will make you aware of how to recognise early signs of pressure damage and the steps you can take to prevent it from occurring. If you feel you need more information or have any concerns please contact your key worker.

Other formats
Please ask any member of the team caring for you if you need this information in large print, Braille, easy read, audio tape or email. Please ask any member of the team if you need help to understand this information in a language that isn’t English.
What is a pressure ulcer?
Pressure ulcers are areas of damage to the skin and underlying tissues. They are sometimes known as pressure sores or bed sores.

What causes pressure ulcers?
Pressure ulcers are caused by a combination of:
- **Pressure**: normal body weight can squash the skin and damage the blood supply to the area. Lying in one position for a long time can cause this.
- **Friction**: poor lifting or moving techniques can remove the top layers of skin or cause blisters.
- **Shearing**: sliding down the bed or chair can damage the skin and deeper layers of tissue. The skin may split and break.

What parts of the body can get a pressure ulcer?

Common pressure ulcer areas
Pressure ulcers can develop anywhere on the body but are mostly found over bony areas such as heels, elbows, hips, bottom and ankles.

Who is most at risk of developing pressure ulcers?
You may be at risk of developing pressure ulcers for a number of reasons including:
- **Problems with movement**: your ability to move may be limited or you may be unable to move at all.
- **Poor circulation**: vascular disease, diabetes or heavy smoking may affect your circulation. Also skin becomes thinner and less elastic as you get older.
- **Problems with sensitivity to pain or discomfort**: some conditions (e.g. diabetes, stroke, spinal injuries) and some treatments (e.g. anti-embolic stockings) may reduce your sensitivity to pain or discomfort. This means you are less likely to move and can increase the severity of a pressure ulcer.
- **Inadequate diet or fluid intake**: poor diet may cause you to be malnourished. Lack of fluid intake may cause dehydration. Losing too much weight can lead to loss of muscle mass over bony areas.
- **Moisture**: urine, faeces and sweat can irritate the skin making it break down more easily.

Early signs of a pressure ulcer
- Change in skin colour - skin may develop reddened areas which remain red when touched. Patients with darkly pigmented skin may develop a purple/blue patch

Example of a patient with early signs (Stage 1) of pressure damage
- Hot and cold patches
- Discomfort or pain
- Blistering

Without appropriate intervention the damage may worsen, developing into hard black skin or become an open wound.

How can you prevent pressure damage?
- **Keep moving**: changing your position regularly helps prevent a build-up of pressure. If you are in bed, try changing sides regularly, sit up slightly and use the flat of your foot and not your heel when pushing yourself up the bed. If you have difficulty moving, your carers may be able to assist you to do this. Your community nurses may be able to supply you with a specialist mattress/cushions.
Where do I go for further advice or information?

- Your local Tissue Viability Champion; there is one based on each ward.
- Your Matron for issues that the Tissue Viability Champion cannot resolve
- The Trust’s Physical Health Matron for more technical advice

Training
Staff may receive training in relation to this procedure, where it is identified in their appraisal as part of the specific development needs for their role and responsibilities. Please refer to the Trust’s Mandatory & Risk Management Training Needs Analysis for further details on training requirements, target audiences and update frequencies.

Training requirements for staff to be confident and competent to undertake this procedure will be provided by Smith and Nephew. Training will be provided on each ward and will be cascaded to all nurses and AHP’s band 3 and above.

Monitoring / Review of this Procedure
In the event of planned change in the process(es) described within this document or an incident involving the described process(es) within the review cycle, this SOP will be reviewed and revised as necessary to maintain its accuracy and effectiveness.

Equality Impact Assessment
Please refer to overarching policy
### Standard Operating Procedure Details

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<th><strong>Unique Identifier</strong> for this SOP is</th>
<th>BCPFT-PH-SOP-01-1</th>
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<tbody>
<tr>
<td>State if SOP is <strong>New</strong> or <strong>Revised</strong></td>
<td>New</td>
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<td><strong>Policy Category</strong></td>
<td>Physical Health</td>
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<tr>
<td><strong>Executive Director</strong></td>
<td>Executive Director of Nursing, AHPs and Governance</td>
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<td>whose portfolio this SOP comes under</td>
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<td><strong>Policy Lead/Author</strong></td>
<td>Physical Health Matron</td>
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<td>Professional Advisory Group</td>
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<tr>
<td>Month/year consultation process completed</td>
<td>May 2015</td>
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<tr>
<td>Month/year SOP was approved</td>
<td>June 2015</td>
</tr>
<tr>
<td>Next review due</td>
<td>September 2018</td>
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<tr>
<td>Disclosure Status</td>
<td>'B' can be disclosed to patients and the public</td>
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**Key words** relating to this SOP: Pressure Ulcer, Pressure ulcer prevention and management care plan, SSKIN Tool, SSKIN Inspection, Water low score 10+, Documented skin inspection, Prevention and management of pressure ulcers patient and carer information leaflet, Areas of the body at risk of developing pressure sores, SSKIN pressure area prevention bundle

### Review and Amendment History

<table>
<thead>
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<th><strong>Version</strong></th>
<th><strong>Date</strong></th>
<th><strong>Description of Change</strong></th>
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<tr>
<td>V1.0</td>
<td>Sep 2015</td>
<td>New Procedure established to supplement Policy for the Prevention and Management of Pressure Ulcers</td>
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