SKIN SAFETY PROTOCOL

SKIN RISK ASSESSMENT AND PREVENTION OF SKIN BREAKDOWN

POLICY

All patients admitted for care in the Neonatal Program will be screened for risk of skin breakdown using the Infant Skin Risk Scoring Tool. This tool is used to assess patients for risk along with a full skin assessment and clinical judgement.

All patients admitted for care in the Neonatal Program will have skin inspections done as part of their routine assessments. Maintenance of skin integrity and prevention of skin breakdown will be managed using the Skin Prevention Bundle.

Purpose: To provide a standardized and consistent approach for assessing and maintaining skin integrity and preventing skin breakdown.

The goals of this protocol are that skin risk assessments, skin inspections and strategies for preventing skin breakdown will be implemented consistently for patients receiving care in the Neonatal Program.

Applicability: Occurs in the Neonatal Program

PROCEDURE

Gather Materials
- Infant Skin Risk Scoring Tool and Skin Prevention Bundle

Registered Nurse

<table>
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<tr>
<th>Procedure</th>
<th>Note</th>
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| **1. Assess** all patients for risk of skin breakdown utilizing the **Infant Skin Risk Scoring Tool, Appendix B**  
  a. On admission  
  b. Every 12 hours with shift assessment  
  c. At significant change and/or deterioration in patient status (e.g. surgery, change in nutritional status, change in mobility)  
  d. At transfer/discharge to another unit or hospital | A modification of the Braden Scale used in the adult population and the Neonatal Skin Risk Assessment Scale, the Infant Skin Risk Scoring Tool was developed to assist nurses to assess infants in the Neonatal Program at BCWI.  
This is a guide and is not at this time a validated tool. |
| **2. Total** scores and document on flow sheet:  
  a. Mild risk: 28-32  
  b. Moderate risk: 20-27  
  c. High risk: 20 or below | Each subscale is ranked from 1 - 4 and then totalled for a score out of 32. The lower the score the higher the risk. |
| **3. Assess** for additional risk factors including:  
  a. Previous history of skin breakdown or pressure ulcer  
  b. Existing skin breakdown or pressure ulcer | Additional risk factors put the patient at higher risk for developing skin breakdown or pressure ulcers. |

Consider these risk factors to:
c. Poor soft tissue coverage: “bony”

d. Prematurity

e. Birth weight less than 1000 grams

f. Marked edema

g. Decreased or no spontaneous activity (sedated, paralyzed, neurologically impaired)
h. Presence of tubing/catheters

i. Presence of Vascular/Arterial access

j. Limited positioning options (ECMO, HFVO, traction, silo)

a) Decide on the frequency of assessments/interventions. The more risk factors associated with a patient as part of the nursing assessment, the frequency may be even more than indicated in the skin bundles to prevent or manage skin integrity/injuries.

b) Develop care plans to address skin integrity along with skin prevention bundles

c) Determine tolerance to skin problems that do not resolve and need to have consultation with physician, wound ostomy care nurse, and/or plastics physician

k. Invasive/non-invasive ventilation

l. Congenital dermatological conditions (ichthyosis, epidermolysis bullosa)
m. Fragile skin, easy bruising

n. Surgical interventions (incisions/ostomies)
o. Administration of vasoactive drugs

4. Complete a head-to-toe skin inspection on all patients every shift and as needed.

**Inspect** and **Palpate** for:

- alterations in skin moisture
- changes in texture, turgor
- change in temperature from surrounding skin (warmer or cooler)
- colour changes (pale, red, purplish hues)
- non-blanchable erythema
- consistency (bogginess or induration)
- edema
- open areas, blisters, rash, drainage

**NOTE:** for darkly pigmented skin, look for purplish/bluish localized areas or localized warm areas that become cool.

The condition of the skin is an indicator of the general health of the patient.

Note the following definitions:

**Blanching erythema** is an early indicator of the need to redistribute pressure.

**Non-blanching erythema** suggests that tissue damage has already occurred or is imminent.

**Indurated (hard) or boggy (soft)** skin is a sign that deep tissue damage has likely occurred.

5. Consider further related assessments:

- BIPP score (pain)
- Medications or medical condition putting them at higher risk for skin breakdown (e.g. inotropes, antibiotics)

6. **Utilize: Skin Safety Flow Chart** (Appendix C) to guide next steps after skin assessment and development of risk assessment score.

Implement Skin Prevention Bundle Strategies, Appendix A
<table>
<thead>
<tr>
<th>Documentation</th>
<th>Note</th>
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<tbody>
<tr>
<td><strong>7. Document</strong> in nursing flow sheet alterations to skin integrity including:</td>
<td>Note the skin integrity problem (data), nursing care or actions to address the problem (action) and infant’s response to the actions in the nursing flow sheet.</td>
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<tr>
<td>a. Anatomical location</td>
<td>Note; Utilize the Types of Skin Injury Documentation Guide Appendix D to describe:</td>
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<tr>
<td>b. Stage of wound injury</td>
<td>1. Stages of extravasations</td>
</tr>
<tr>
<td>c. Size in centimetres</td>
<td>2. Stages of wound injury</td>
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<tr>
<td>d. Type of tissue at the wound base</td>
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<tr>
<td>e. Presence of exudates/odor</td>
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<tr>
<td>f. Wound margins</td>
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<tr>
<td>g. Peri-wound skin condition</td>
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<td><strong>8. Document in the “Prevention” section under Skin assessment the strategy</strong></td>
<td>Note: The risk score obtained is only a guide to help nurses decide on initial steps to prevent skin problems. Further assessments and clinical judgement are also needed to develop a comprehensive care plan for each patient.</td>
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<tr>
<td>(Red-R, Yellow-Y or Green-G) that was reviewed and or implemented for the shift.</td>
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<td><strong>9. Confirm that based on score, the skin prevention strategies, as applicable,</strong></td>
<td></td>
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<td>have been done to prevent skin breakdown. Activate strategies that have not been implemented. If risk score changes adjust strategies that correspond to the current score.</td>
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<td><strong>10. Communicate skin risk assessment, skin status, and plan of care when</strong></td>
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<td>transferring care to another provider such as at change of shift, at rounds, when</td>
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<td>transferring to another facility, and at discharge.</td>
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**DOCUMENTATION**

- Bedside Information Tool
- Nursing flow sheet

**REFERENCES**


SKIN SAFETY PROTOCOL


APPENDIX

| Skin Prevention Bundle Activities | Appendix A |
| Infant Skin Risk Score and Skin Prevention Bundle Tool | Appendix B |
| Skin Safety Care Flow Chart | Appendix C |
| Types of Skin Injury Documentation Guide | Appendix D |