a S S K I N g

Green Care Plan at DBTH

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

For pressure ulcer prevention 7 key principles are required, commonly referred to as 'aSSKINg'. The framework is a tool which brings together best practice with the aim of minimising variation in care, recommended by the National Wound Care Strategy Programme (2023). Click on the hyperlinks for more information.

Principle		Action
a	Assess risk (Risk Assessment)	Undertake a PURPOSE T screening tool and where required a risk assessment within 6 hours of arrival to the Trust.
		Update the PURPOSE T screening and where required a risk assessment at each condition and environment change within 6 hours or at least weekly.
s	Skin assessment and skin care	Undertake a 26 point skin inspection, including skin under devices where it is safe to do so, alongside the risk assessment.
		Consider colour, texture and temperature of the skin.
		Ask the individual to identify any areas that are painful, itchy, uncomfortable or numb.
		Apply emollient daily to keep the skin well hydrated and promote skin integrity.
		Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation.
s	Surface (Equipment)	Use a standard Emergency Trolley OR bed frame with a Static Foam Mattress OR bed frame with a Mercury Advanced Hybrid Mattress without a Pump.
		Consider the impact of medical devices and there contact with the skin and use preventive techniques where required as per the Medical Device Pressure Ulcer Prevention Guidance.
k	Keep moving (Repositioning)	Encourage the patient to reposition throughout the day.
		Undertake a falls risk assessment and moving and handling risk assessments to balance the risk from other harm.
i	Incontinence or increased moisture (Moisture associated skin damage MASD)	Keep the skin clean, dry and maintain hydration.
n	Nutrition (Nutrition and Hydration)	Undertake a MUST assessment with 24 hours of arrival to the Trust. Utilising relevant tools such as BMI and MUAC.
		Commence a food and/or fluid balance chart where required as per MUST guidance.
		Encourage oral intake of diet and fluids where clinically safe to do so.
g	Give information	Consider the patient's level of capacity and perform the necessary checks.
		Use the clinical record to documentation to ensure information is available to the inter-professional team.

Developed by The Skin Integrity Team April 2024. For review July 2027.
Bases on the National Would Care Strategy Programme Pressure Ulcer Recommendations.