Neonatal Unit
aSSKINg Care Plan at DBTH

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

a. Assess Risk

- The RGN/RSCN must perform the PURPOSE T Pressure Ulcer Risk Assessment for all babies following the initial skin inspection within 1 hour of admission/upon transfer from another NNU.
- Reassessment may be required in the event of deterioration as skin integrity could be threatened due to reduced oxygenation. Otherwise reassess at: **Green** = If deterioration occurs, **Amber** **or** **Red** = If deterioration occurs/ weekly as a minimum.

S. Skin assessment and skin care

- All babies must have their skin inspected within 1 hour of admission/upon transfer from another NNU and at care times (minimum of 3 hourly) by a RGN/RSCN.
- Babies are at an increased medical device related pressure ulcer (MDRPU), such as CPAP. Refer to the Prevention of Medical Related Pressure Ulcers (MDRPU) guidance for further information.
- The Pressure ulcer prevention and management Care Plan (WPR41963) must be commenced for all babies who have been identified as either **RED** or **AMBER** risk status.
  Identify and document all pressure ulcers on the Skin Integrity Wound Identification Care Sheet and Skin Integrity Wound Assessment Care Plan
- Assessing wounds using the T.I.M.E.S wound assessment tool allows the principles of wound bed preparation to be understood.
- This focuses on the removal of barriers to healing i.e. debridement, moisture balance and control of bacterial burden enabling wound healing to progress.
- The Skin Integrity Datix/Dashboard should be completed for all pressure ulcers.
- Ward/department staff must perform the initial scoping to determine if there are any potential safeguarding concerns of neglect relating to pressure area care and alert the Safeguarding Team.
- For all children follow the safeguarding children referral processes.
- Staff can contact the Safeguarding Team on 01302 642437 for advice and support.

S. Surface

- Ensure equipment continues to function and there are no issues with humidity for respiratory support devices. High flow and CPAP are to be set on invasive mode with the humidity chamber reading at 37°c and the wire temperature reading at 40°c. Environmental temperature can impact on the humidity levels in the chamber if the readings are out of the normal range for prolonged periods, ensure the equipment is not faulty and seek support from senior staff if required.
- Change SpO2 monitoring probe 3 hourly, frequently.
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K. Keep moving (repositioning)

- Relieving the pressure is the key to healing areas but can also prevent damage from occurring.
- Medical devices must be repositioned frequently to minimise the pressure and friction to vulnerable skin areas and can reduce the severity of nasal injury if there is damaged tissue.
- If the baby does not tolerate frequent pressure relief from respiratory support or for long periods this must be documented.
- Ensure that prong pressure is relieved 3 hourly.
- Babies requiring CPAP will require their mask and prongs alternating at least every 6 hours if tolerated.
- All pressure relief interventions and repositioning must be charted. If there are any exceptions e.g. babies are too unstable for pressure relief, this must be documented.

I. Incontinence

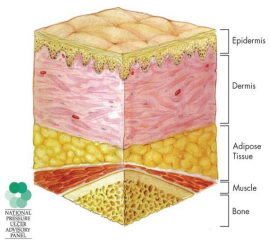
- Identify the cause of moisture-related skin damage i.e. Incontinence, sweat, saliva, stoma, wound leakage.
- Implement appropriate prevention strategies as per the Pathway for Skin Care Regime for Moisture Associated Skin Damage (MASD) where there are signs of MASD.
- Keep the skin clean and dry using a pH balanced soap substitute.

N. Nutrition and Hydration

- Electrolyte imbalance can be a significant problem during the neonatal period.
- Good nutrition improves neurological outcome and reduces incidence and severity of chronic lung disease in preterm infants.
- Maternal breast milk provides optimal nutrition for preterm infants and reduces the incidence of necrotising enterocolitis.
- Enteral nutrition should be initiated as early as possible – usually within first 48 hours of birth unless significant medical/surgical contraindications.

g. Giving Information

- Select and implement the most appropriate communication approach to parents and carers to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies.
  Use the clinical record to documentation to ensure information is available to the inter-professional team.
- Identify and document all pressure ulcers using the European Pressure Ulcer Advisory Panel guidelines, on the Skin Integrity Wound Identification Care Sheet and Skin Integrity Wound Assessment Care Plan.



Safeguarding
Children & Adults