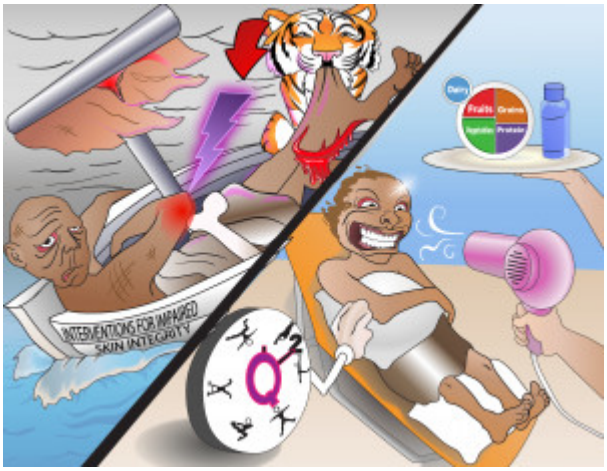
Interventions for Impaired Skin Integrity

Interventions for impaired skin integrity first include an adequate assessment. Patients should be observed for signs of skin breakdown. These include pain, redness, turgor and bleeding. Bony prominences should also be examined. After a thorough assessment, appropriate interventions are then taken. These are not limited to repositioning the patient every 2 hours, pressure relief with pillows, maintaining clean and dry skin, as well as adequate nutrition and hydration.



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Assessment

Signs of Skin Breakdown

Skin Breaking down

Skin breakdown is caused in several ways including friction, shear, pressure, and moisture. Signs to look for include redness, discoloration, cracks, rashes, scabs, blisters, dry, raised, or shiny skin.

Pain

Pain-bolt

Pain may be one of the first signs to indicate a patient is uncomfortable. It is important to assess the cause of the pain and implement interventions such as a position change to reduce the risk of skin breakdown.

Redness

Redness

Skin breakdown occurs when skin, soft tissue, and blood vessels are compressed, cutting off blood circulation, thus starving the tissue of oxygen and vital nutrients. The body tries to compensate by sending more blood to the area, resulting in redness and swelling.

Decreased Skin Turgor

Turgor-tiger

Decreased skin turgor is a late sign of dehydration and can alert the nurse to be especially diligent in assessing the entire body for signs of skin breakdown. To assess turgor, start by grasping an area of the skin such as the back of the hand between two fingers so that it is tented up. Skin with decreased turgor remains elevated and returns slowly to its normal position.

Bleeding

Bleeding

Bleeding is another indicator of skin breakdown. Wash the affected area with warm soap and water and loosely cover if necessary.

Bony Prominences

Bony Prominence

Bony prominences, most notably the elbows, ankles, occiput and sacrum are at risk for impaired skin integrity and pressure ulcers. Thus, when assessing patients at risk, these locations should be well examined.

Intervention

Reposition Q2H

Repositioned every 2 hours clock

Changing the patient's position frequently and turning them every 2 hours is vital to maintaining skin integrity. This can be done with the use of pillows to shift body weight and reduce pressure, especially along bony prominences such as the back of the head, shoulder blades, elbows, sacrum, and heels.

Pressure Relief

Pillows

Use devices to relieve pressure such as pillows under heels or lower back. Rotational beds may also be seen in the hospital setting and are effective in automatically relieving pressure.

Maintain Clean and Dry Skin

Cleaning off with a Blow-dryer

Excess moisture over-hydrates the skin, making it weak and more prone to friction, shear, and breakdown. It is vital to frequently assess the body for sources of skin moisture such as sweating, bowel and bladder accidents, and drainage from wounds.

Adequate Nutrition and Hydration

Nutritional-plate and Water-bottle

A balanced diet consisting of an adequate intake of protein, vitamin C, vitamin A, and zinc along with a proper intake of fluids aids the body to prevent or heal wounds.