The aSSKINg Framework

	Action	Best Practice
a	**Assess risk**	Consider risk factors associated with compromised skin integrity. Undertake screening and risk assessment using the PURPOSE T screening and risk assessment tool or similar evidence-based and validated tool which contains as a minimum, the same risk elements. Refer to appropriate members of the interprofessional team. Be aware of safeguarding policies and take appropriate action when necessary. Document risk status and timing of review in the clinical record.
S	**Skin assessment and skin care**	Carry out a comprehensive skin assessment including skin under devices where it is safe to do so. Consider colour, texture and temperature of the skin. Ask the individual to identify any areas that are painful, itchy, uncomfortable or numb. Consider risk factors associated with impaired skin integrity. Identify complex health conditions that affect skin integrity. Keep the skin clean, dry and well hydrated. Implement evidence-based skin interventions to 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**	Consider risk factors associated with a range of support surfaces including but not limited to beds, mattresses, chairs, cushions, wheelchairs and in vehicle systems. Consider the impact of offloading devices such as boots or other orthoses. Consider the impact of medical devices and their contact with the skin. Consider the range of available equipment, including the mechanism of action, benefits and associated risks. Identify and undertake relevant seating and moving and handling risk assessments. Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk of pressure ulcer development. Refer to appropriate members of the inter-professional team throughout the patient journey, including discharge planning.

K	**Keep moving**	Consider level of mobility and risk factors associated with reduced mobility. Consider the range of available moving and handling equipment, including the mechanism of action, benefits and associated risks. Use relevant formal tools to assess mobility - falls risk, moving and handling risk assessments to balance the risk from other harm. Consider the impact of reduced mobility on an individual's posture, engagement in activities of daily living (ADL) and psychosocial functioning (mood, isolation, social engagement). Safely use a range of appropriate equipment to promote self mobilisation and good posture - hoists and slings, standing hoists and frames, electronic bed frames, appropriate seating and mobility aids, sleep systems, wheelchairs etc - to promote individualised plan of mobility and assisted transfers. Refer to appropriate members of the interprofessional team throughout the planning journey, including discharge planning. Consider the individual's usual daily routine when planning repositioning or activity schedules. Identify and understand and, where possible, address the cause of any change in mobility level.
I	**Incontinence or increased moisture**	Identify the cause of moisture-related skin damage ie. incontinence, sweat, saliva, stoma effluent, wound leakage. Where possible, address the cause of the moisture. Consider whether incontinence-related skin damage is an issue. Differentiate between aetiologies associated with incontinence. Consider how increased moisture increases the risk of skin damage caused by skin and friction. Implement appropriate prevention and management strategies. Refer to continence services where necessary. Keep the skin clean, dry and well hydrated. Maintain hydration.

N	**Nutrition**	Consider the impact of key nutritional elements in wound healing. Understand the impact of disease on nutritional need and nutrient absorption. Utilise the relevant tools and documentation which should include food and fluid charts, for example, food diaries, MUST, BMI, MUAC, bloods, feeding risks and PEM assessment. Advise on food fortification, nutritional supplementation and moderation of dietary restrictions in event of pressure ulceration. Collaborate to deliver appropriate care with relevant members of the multidisciplinary teams (MDT) (dietician, speech and language therapist, occupational therapist). Consider the practical elements of maintaining nutrition and hydration including portion sizing, food texture, access and ease of use of implements and good dentitition.
g	**Give information**	Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies. Consider the patient's level of capacity and perform the necessary checks. Communicate effective and safe use of interventions effectively for the patient, family and within the MDT. Recognise when clinical concerns need to be escalated. Promote effective pressure ulcer prevention approaches. Consider effective resource allocation and escalate concerns when resources are unavailable. Be aware of safeguarding policies and take appropriate action when necessary. Use the clinical record as the source of documentation to ensure information is available to all members of the MDT. Use appropriate language to ensure the clinical record can be appropriately used for coding/analytic purposes. When capturing/using digital images, ensure appropriate consent has been obtained.