

- Routinely assess the child's nutritional status. A child who is not permitted to take fluids by mouth (nothing by mouth [NPO]) for several days and is receiving only IV fluid is nutritionally at risk, which can also affect the skin's ability to maintain its integrity. Consider parenteral nutrition.

Assessment of the skin is easiest to accomplish during the bath. Examine for early signs of injury. Risk factors include impaired mobility, protein malnutrition, edema, incontinence, sensory loss, anemia, infection, failure to turn the patient, and intubation. Critically ill children are at a higher risk of pressure ulcers and skin breakdown, because they often have several risk factors combined. The incidence in these children has been reported as high as 27% (Curley, Quigley, and Lin, 2003). Identification of risk factors helps to determine children who need a more thorough skin assessment. Several risk assessment scales are available for use in pediatrics, such as the Braden Q Scale (Curley, Razmus, Roberts, et al, 2003) and the Glamorgan Scale (Willock, Baharestani, and Anthony, 2009). Assessment should occur within 24 hours of admission to identify pressure ulcers and wounds that occurred before admission.

When capillary blood flow is interrupted by pressure, the blood flows back into the tissue when the pressure is relieved. As the body attempts to reoxygenate the area, a bright red flush appears. This **reactive hyperemia**, or flush, is the earliest sign of tissue compromise and pressure-related ischemia. If pressure is prolonged, reactive hyperemia will not be sufficient to revitalize ischemic tissue. Pressure ulcers can develop when the pressure on the skin and underlying tissues is greater than the capillary closing pressure, causing capillary occlusion. If the pressure remains unrelieved, vessels can collapse, resulting in tissue anoxia and cellular death. Pressure ulcers most often occur over bony prominences. These lesions are usually very deep (stage IV), extending into subcutaneous tissue or even more deeply into muscle, tendon, or bone.

Pressure ulcers are staged to classify the amount of tissue damage that has occurred.* Necrotic tissue must be removed so the tissue depth can accurately be assessed. Accurate documentation of redness or obvious skin breakdown is essential. Color, size