Are we asking too much? Could we all talk the same language? Let's be radical and all do the same!

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I hear on a daily basis of the real struggles in clinical practice and how passionate clinicians are failing to make the impact they hope to achieve because those delivering the care are just so overwhelmed. I see increasingly creative ways of delivering education and creating amazing, simple, intuitive point of care documentation in the hope of engaging ground floor clinicians' attention and equally spirals of administration when those measures fail. But nothing seems to grab clinician's attention or fire their passions, we can't enthuse them about maintaining healthy skin in the way we would like.

How do we make skin a priority for everyone —everywhere? Have we made it too special and too complicated? We all have our own special groups and pathways and guidelines and all kind of other things, whether that is for pressure ulcers (PU), leg ulcers, diabetic foot ulcers or skin tears but where is the commonality — aren't we all trying to achieve the same thing — maintain healthy skin?

Are we confusing healthcare professionals with our oh so specialist and targeted messages, our wealth of clever acronyms and why 'our wound type' is the one to be concerned about?

Could we all do the same? Of course I am going to propose we all follow a PUs model but hang on, bear with me and see what you think.

Doesn't aSSKINg apply to all our wounds? Haven't they all got risk factors that we assess? Don't they all need us to assess the skin and keep it clean dry and well hydrated? Doesn't the surface(s) play and important role whether that is an offloading device a mattress, a compression bandage or protecting vulnerable skin from sharp surfaces? Keeping patients moving is such an important part of all healthcare why make it something specific, keeping them moving prevents deconditioning, loss of muscle mass, reduced mood, it prevents PUs, it increases blood flow, prevents complications like chest infections, it's a really fundamental aspect of what we do! What about managing increased moisture and incontinence — so we need to make that a specific element — isn't it just common sense and good practice? The same as monitoring nutrition and hydration, these are not specific to PU prevention, these are about keeping a patient well, returning them to independence (or as much as we can). And surely giving information is the same, whether it is sharing information across a healthcare team, creating good clinical records, delivering education to patients or indeed staff or carrying out amazing health promotion campaigns — shouldn't we all have the one really key message — "keep the skin safe, keep it clean, dry and well hydrated". Maybe the strap line could be Love Great Skin (yes I know it's another PU reference, but isn't it true?)

For Stop the Pressure Day this year we are going with the theme of Every Contact Counts and doesn't it just, not just every clinical contact (so who is seeing the patient and when) but every time someone or something touches the skin, that really matters, it can hurt or heal, incontinence or emollient, a sharp edge or an offloading boot. Everything in contact with the skin matters.

So have a look at my *Table 1*, see what you think! Let's prevent as much skin harm as we can, just imagine if we all did the same in all the blue columns there's only a small bit extra in the specifics.

We have a common objective to prevent a wound or wound complication such as delayed healing, we could help by making it simple for staff to do.

This is not a complete or accurate table, but just

Table 1. aSSKINg for all

	assess Risk	**S**kin care **Let's all do the same!**	**S**urface	**I**ncreased moisture / incontinence **Let's all do the same! Please manage incontinence well irrespective of why!**	**N**utrition and hydration **Let's all do the same!**	**g**ive Information Patient information / supported self care **Let's all do the same!**
PU	Use a risk assessment tool (preferably PURPOSE T) Immobility	Clean, dry, rehydrate and protect Skin assessment	Surfaces: bed chair devices heel protection Manual handling	Manage any increased moisture usually incontinence and sweat	Assess nutrition and hydration status – and keep patient well fed and hydrated	Communicate with the team Communicate with the patient and family Document clearly in the clinical record Promote patient engagement
Leg ulcers	Risk factors – e.g. Cardiovascular disease, DVT, Obesity Poor mobility	Clean, dry, rehydrate and protect Skin assessment	Compression materials Manual handling	Leaky legs Incontinence can increase risk of infection	As above	As above
Foot ulcers	Foot screen Ischaemia Infection Neuropathy immobility	Clean, dry, rehydrate and protect Skin assessment	Offload / pressure redistribution	Leaky if got oedema otherwise dehydration	As above	As above
SWC	Type of surgery Multi morbidity Obesity	Clean, dry, rehydrate and protect Skin assessment	Pre / Intra op positioning and aids Post operative support for the wound e.g. NPWT	Increased risk of fungal infection in moist folds	As above additional Hydration e.g. if NBM Glycaemic control	As above
Skin tears	Falls risk Skin condition Dementia Decreasing mobility	Clean, dry, rehydrate and protect Skin assessment	Protect from sharp surfaces Wear protective clothing (long sleeves, trousers)	Managing incontinence – urgency can increase risk of knocks and bangs	As above	As above
	Immobility Presence of moisture	Clean, dry, rehydrate and protect Skin assessment	Keep interface dry	Manage any source of moisture, incontinence, stomal effluent, saliva, wound exudate	As above	As above

think if you populated it fully, if we listed all the risk factors for each wound type. How many would be common? Multimorbidity, Immobility, poor blood supply, poor sensation, obesity, diabetes….. how many of the actions would be the same? Is a skin assessment any different for any of these?

Just one last thought, couldn't we just assess for frailty… I'll leave that with you to ponder on.

P.S. if you really think it's too pressure ulcerish we could just change it to RiSSKINg (risk assessment works every bit as well as Assess risk) and have a whole new way of working!