SKIN RISK ALERT
SKIN BUNDLE INTERVENTIONS IN EFFECT!

SURFACE:
- Be sure patient is on correct type of mattress.
- Do not use multiple layers of linens under patient.
- Keep linens free of wrinkles.
- Be sure patient is not lying on tubing, telephones or call bells.

KEEP TURNING:
- Reposition patient at least every two hours when in bed.
- “Self” is not acceptable for documenting repositioning.
- Document the actual position the patient is observed in.
- Shift patient’s weight at least every hour if up in chair.
- Use a chair pad when patient is up in a chair.

INCONTINENCE:
- Offer toileting assistance every two hours.
- If incontinent, give perineal care every two hours and as needed for stool incontinence.
- Apply a moisture barrier after incontinence care.
- If not incontinent, apply moisture barrier every 8 hours.
- Avoid diapers unless needed for containing excessive amounts of stool, patient is ambulatory and incontinent or saturates linens with most urinary incontinence episodes or patient requests diaper.

NUTRITION:
- If patient has a nutritional deficit or is high risk for a nutritional deficit, order a nutrition consult. Look at what the patient has been taking in for nutrition and also look at albumin levels.
- Consider recent weight loss as well.
- Consider hydration status.
- Carry out nutrition orders and record supplement and meal intake.

Assess skin every eight hours. Document breakdown description on Skin Flow Sheet daily.

Document all of your interventions.

For more information visit http://www.patientsafetyauthority.org

This figure accompanies Skin and soft-tissue infections in long-term care. Pa Patient Saf Advis [online] 2011 Mar [cited 2011 Mar 1].

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