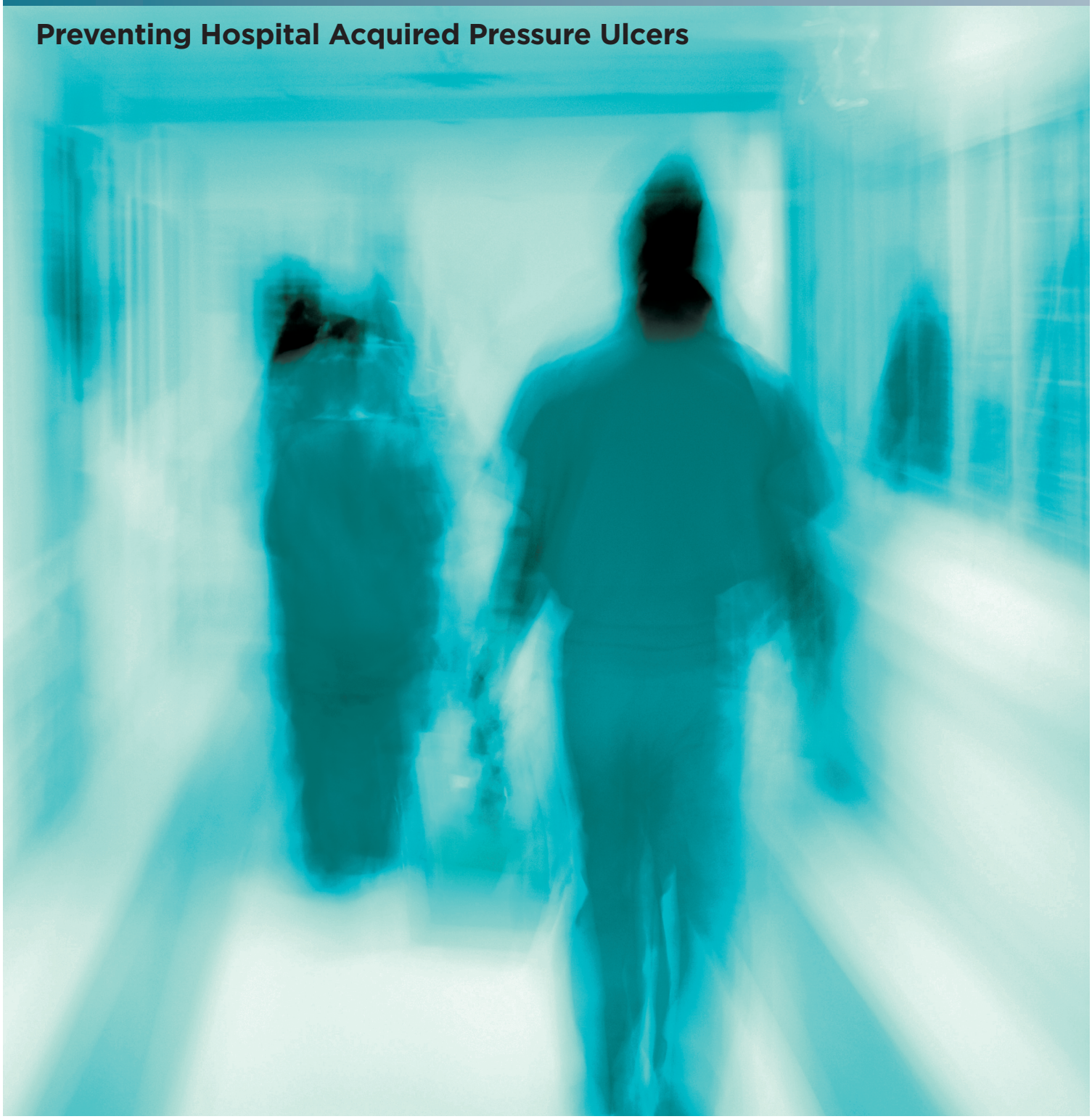
HOSPITAL ACQUIRED PRESSURE ULCERS (HAPU) CHANGE PACKAGE

Preventing Hospital Acquired Pressure Ulcers



American Hospital Association

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
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HOSPITAL-ACQUIRED PRESSURE ULCER PREVENTION OVERVIEW

Background

- Pressure ulcers cause significant patient harm, including pain, infections, and extended hospital lengths-of-stay.
- Cost of treating a single full-thickness pressure ulcer is as high as $70,000 and total costs for treatment of pressure ulcers in the U.S. is estimated at $11 billion annually.[12]
- Pressure ulcer incidence rates vary considerably by clinical setting – ranging from 0.4% to 38% in acute care, from 2.2 to 23.9% in long term care, and from 0% to 17% in home care.[1]

Suggested AIMs

- Reduce the prevalence of hospital acquired Stage II or greater pressure ulcers by 50% by December 31, 2013.
- Reduce the incidence of significant hospital acquired Stage III-IV pressure ulcers by 50% by December 31, 2013.

Potential Measures

Outcome: The percentage of patients with at least one Stage II or greater hospital-acquired (not present on admission) pressure ulcer on the day of the prevalence study

The number of patients who develop significant (stages III & IV) hospital-acquired pressure ulcers — (rate per 1,000 discharges)

Process: Skin assessment is documented within 4 hours of admission and daily thereafter

Pressure ulcer risk assessment is completed within 24 hours of admission and daily thereafter

Compliance is demonstrated with prevention interventions for patients at risk for skin breakdown

PRIMARY DRIVER	IDEAS TO TEST
Conduct Skin Evaluation/Risk Assessment & Reassessment	• Use of a head-to-toe skin and risk assessment as soon as possible, within 4 hours upon admission to the hospital. • Utilize a validated standard tool for the skin and risk assessment with subscales to drive individual risk and intervention. • The risk and skin assessment should be age appropriate. Pediatric versus Adult. • Skin Assessment and Reassessment of risk daily or more frequently for high-risk patients.
Manage Moisture	• Keep the patient dry and moisturize the skin only if necessary. • Use a moisture barrier to ensure the skin is protected. • When necessary, use under-pads with a quick-drying surface that wick moisture away from skin. • Set specific time intervals to remind staff to reposition, offer toileting and PO fluids, and reassess for wet skin, i.e. the 3 P's – Pain/Potty/Position-Pressure. • Keep supplies handy at the bedside in the event a patient is incontinent.
Optimize Hydration and Nutrition	• Give patients food and drink preferences to encourage good hydration and nutrition. • Provide at-risk patients with a water container in a unique color so staff and families will be guided to encourage hydration. • Provide nutritional supplementation if needed and not contraindicated. • Consult a Registered Dietician if the patient is at high risk. • Monitor weight status, food and fluid intake, hydration status, and laboratory test results.
Minimize Pressure	• Turn and reposition patients at least every two hours as reminded by visual or musical cues, bells, and alarms at the nurses' station. • Use special beds, mattresses, and foam wedges to redistribute pressure on the skin. • Use the NPUAP Guidelines for alignment. • Use lifting devices, glide sheets, or special dressings for the sacral area to reduce shearing or friction during movement.

Making Changes

- This intervention is in the Collaborative with Reducing Pressure Ulcers and VTEs **(PIVOT Collaborative)**. National meetings, webinars, monthly coaching calls, change packages and other tools will augment state association activities.

Key Resources

- AHRQ Toolkit — Preventing Pressure Ulcers in Hospitals Retrieved at http://www.ahrq.gov/research/ltc/pressureulcertoolkit/
- AHRQ Guideline Synthesis on Preventing Pressure Ulcers Retrieved at http://www.guideline.gov/syntheses/synthesis.aspx?id=25078
- National Pressure Ulcer Advisory Panel Retrieved at http://www.npuap.org/
- IHI How to Guide Reducing Pressure Ulcers Retrieved at http://www.ihi.org/knowledge

HOSPITAL-ACQUIRED PRESSURE ULCER DRIVER DIAGRAM 2012-2013

AIM: Reduce the prevalence of hospital acquired Stage II or greater Hospital Acquired Pressure Ulcers (HAPU) by 50% by 12/31/13

PRIMARY DRIVER	SECONDARY DRIVER	CHANGE IDEAS
Conduct Skin/ Risk Assessment & Reassessment	• Implement a head-to-toe skin evaluation and risk assessment tool	• Utilize a validated standard tool for the skin evaluation and risk assessment. • Assess the skin and risks within 4 hours of admission. • Assess skin at least daily and along with other routine assessments. • The risk and skin assessments should be age appropriate. Pediatric versus Adult. • Visual cues should be available to promote the completion of the assessment. • Use multiple methods to visually identify patients at risk. Use visual cues in the patient's room, on the door, or on the front of the medical record. • Reassess risk for HAPU at least daily. Develop documentation tools that prompt daily skin inspections and use subscales to assess individual risk and drive interventions. • Develop an individualized plan of care to reduce the risks of pressure ulcers. • With patient consent, photograph and document skin issues present on admission. • Conduct nurse-to-nurse shift reports at the bedside and include skin assessment with 2 sets of eyes. Document and address findings.
Manage Moisture	• Avoid skin wetness; protect and moisturize as needed	• Use topical agents that hydrate the skin and form a moisture barrier to reduce skin damage. Consider using all-in-one cleaning/moisture-barrier clothes. • Set specific timeframes or create reminder systems to reposition; frequently offer toileting, PO fluids, and reassess for wet skin. Remember the 3 P's – Pain/Potty/Position-Pressure. • Involve licensed and unlicensed staff such as nurse's aides in every hour rounding and checking for the 3 P's. • Consider a Stage I pressure ulcer as a "warning sign." • Use under-pads that provide a quick-drying surface and wick moisture away from skin. Keep supplies readily available at the bedside in case the patient is incontinent. • Develop a skin-care cart with supplies and a guide for how to manage skin issues according to severity. • Combine interventions with other routine activities. • Identify a staff nurse for each unit to serve as a skin care resource. • Avoid using a thick paste as a cleansing/moisture barrier (staff may have difficulty cleaning the paste when stool is present and may injure the skin).

PRIMARY DRIVER	SECONDARY DRIVER	CHANGE IDEAS
Optimize Hydration and Nutrition	• Monitor weight, nutrition and hydration status	• Give patients their food/liquid preferences to enhance hydration and nutrition. • Provide nutritional supplementation if needed and not contraindicated. • Generate an automatic Registered Dietician consult if the patient is at high risk. • Monitor weight, food and fluid intake, and laboratory test results. • Provide at-risk patients with a water container of a unique color so staff and families will know to encourage hydration. • Assist the patient with meals if needed and encourage snacks. • Offer water to the patient when rounding for the 3 "P's". Pain/Potty/Position
Minimize Pressure, Shear & Friction	• Turn and reposition patients at least every two hours. • Develop and institute early mobility/ambulation protocols	• Use visual or musical cues, e.g. a turning clock, bells, and alarms, at the nurse's station as a reminder to turn and reposition the patient. • Use visual cues at the bedside to remember turn the patient, e.g. a turning clock or whiteboard that displays the time for the next turn. • Establish 'rules' for which side patients should lie on at certain times (e.g. even hours on right side, odd hours on left side). • Ensure pressure-reducing equipment is available at all times. (e.g. Beds, mattresses, and foam wedges, etc.). Use a device that elevates the heel and prevents external rotation of the ankle and foot. • Use special beds, mattresses, foam wedges, and use pillows (only for limbs) to redistribute pressure. • Operating room tables should be covered by special overlay mattresses. • Use breathable glide sheets and or lifting devices to prevent shear and friction. • Use ceiling lifts to encourage mobility and movement and to prevent staff work-related injuries. • Limit layers of linen to no more than 3 (using more than 4 layers has been shown to be an independent risk factor for HAPU). A breathable glide sheet that is helpful for in-bed mobility and lifts are best for out-of-bed mobility.

PREVENTION OF HOSPITAL-ACQUIRED PRESSURE ULCERS (HAPU)

More than 2.5 million patients in U.S. acute-care facilities suffer from pressure ulcers, and 60,000 die from pressure ulcer complications every year (2009). Hospital-acquired pressure ulcers result in pain, expensive treatments, increased length of institutional stay, and, in some patients, premature mortality. Interventions that can help to prevent pressure ulcers or treat them quickly if they develop can reduce the costs of HAPU care and improve quality of life for those affected.

SUGGESTED AIMS

An AIM statement for HAPU reduction initiatives could encompass one of the following:

- Reduce the prevalence of Stage II or greater Hospital-Acquired Pressure Ulcers (HAPU) by 50% by December 31, 2013.
- Reduce the incidence of significant Hospital-Acquired Stage III-IV Pressure Ulcers by 50% by December 31, 2013.

CONDUCT SKIN/RISK ASSESSMENT & REASSESSMENT

Prevention of pressure ulcers should begin with an assessment of a patient's risk for such ulcers. This assessment must be done upon admission and then at least daily during a patient's stay, and should include evaluation of the condition of the patient's skin.[3] Risks for the development of pressure ulcers include advanced age, immobility, incontinence, inadequate nutrition and hydration, neuro-sensory deficiency, device-related skin pressure, multiple co-morbidities, and circulatory abnormalities.[4]

Secondary Driver: Adopt risk assessment tool which includes a head-to-toe skin evaluation.

Adequate assessment of a patient's risk with an accurate tool will allow the care team to implement timely prevention strategies for each patient.

Change Ideas: Skin Assessment Strategies

- Utilize a validated standard tool for risk assessment. The most widely used is the Braden Scale[5]; others include the Norton, Gosnell, Knoll, and Waterlow Scales.[6]
- Assess risk and evaluate skin within 4 hours of admission.
- Evaluate skin at least daily and during routine assessment. Develop documentation tools to prompt daily skin inspections and use subscales to assess for individual risk and drive interventions. In acutely ill patients, skin condition can change rapidly, and multiple reassessments may be indicated.[7]
- Assessments should be age appropriate, e.g. pediatric versus adult.[8]
- Develop cues to ensure the completion of the assessment, such as an admission checklist or part of charge nurse rounds.
- Use multiple methods to identify patients at risk. For example, place visual cues on the door of the patient's room, on the front of the medical chart, etc.[9]
- With patient consent, use an authorized camera to photograph and document skin issues at admission and beyond.
- Develop an individualized plan of care for each patient to reduce the risks of pressure ulcers.
- Conduct nurse-to-nurse shift reports at the bedside which review the skin areas of concern. (Skin assessment with 2 sets of eyes can improve reliability of skin assessment and documentation.)

Suggested Process Measures

- Monthly audit for the percentage of patients who received risk assessment and skin evaluation on admission
- Monthly audit for the percentage of patients who had daily reassessment performed

"Hardwiring" Skin/Risk assessment and reassessment in Improvement Plans

Hardwiring methods include incorporating skin and risk assessments in the admission process and as part of other routine assessments.[10] The skin and risk assessment tool selected should be incorporated into the standard documentation; for example, by developing an admissions checklist that lists all the necessary elements of skin and risk assessment. If using electronic health records, a force function can require that a skin and risk assessment is completed before the provider signature is accepted. Descriptors of each area of risk should be listed in both paper and electronic documentations to ensure reliability of the assessments.

MANAGE MOISTURE

Avoiding inappropriate wetness and optimally moisturizing skin can reduce the risk of developing pressure ulcers.[11]

Secondary Driver: Avoid skin wetness and optimally moisturize.

Limit exposure of a patient's skin to moisture from sources such as incontinence, wound drainage, or perspiration. Use underpads that wick away moisture and present a dry surface to the skin.[12] Topical agents are available that will provide a barrier to wetness and simultaneously moisturize the skin.[13]

Change Ideas: Reliable Moisture Management

- Use topical agents that hydrate the skin and form a wetness barrier to reduce skin damage. Consider using all-in-one cleaning/moisture-barrier clothes, which ensure that protection is never forgotten.
  - — Diapers should only be used to preserve a patient's dignity when he or she is up in a chair or walking. They **must** be removed on returning to bed.
- Set specific time intervals with reminder alerts to reposition patients. Offer frequent toileting and PO fluids, and reassess for wet skin. Remember the 3 P's – Pain/Potty/Position-Pressure.
- Ask licensed and unlicensed staff such as nurses' aides to make rounds and check the 3 P's every hour.
- Consider a Stage I pressure ulcer as a "critical warning sign."
- Use under-pads that wick moisture away from the skin and provide a quick-drying surface.
- Keep supplies readily available at the bedside in the event a patient is incontinent.[14]
- Develop a skin-care cart that provides supplies, and a guide for how to manage skin pathology according to severity and degree, to reduce process variation.
- Combine skin care with other routine activities as per protocols.
- Identify a staff nurse in each unit to serve as a skin care resource.
- Avoid using a thick paste as a cleansing/moisture-barrier (staff may tend to have difficulty removing or cleaning the paste when stool is present, resulting in skin injury).

Suggested Process Measures

- Audit compliance with hourly rounding and checking the 3P's through random spot checks.
- Perform random spot checks to determine the percentage of rooms with supplies available for incontinent patients

Balance Measure

- Assess the incidence of incontinence-associated dermatitis.

"Hardwiring" Moisture Management as part of improvement plan

Making skin care and HAPU prevention part of the everyday routine of nursing staff is a reliable hardwiring tactic. Identify periodic activities such as hourly rounding, repositioning, assessing for wet skin, applying barrier agents, and offering oral fluids and toileting opportunities, and include them in nursing protocols for licensed and non-licensed staff to complete and document, as appropriate. [15]

OPTIMIZE HYDRATION AND NUTRITION

Nutrition and hydration status affect skin condition and risks for pressure ulcers. Patients with nutritional deficiency may be twice as likely to develop skin breakdown.[16] Risk assessment for pressure ulcer development should include a review of the patient's nutrition and hydration status.

Secondary Driver: Assess weight, nutrition and hydration status.

Patients with nutritional intake and hydration deficits frequently lose weight and muscle mass, making bones more prominent and reducing mobility. Poor nutrition and hydration may promote edema and reduce blood flow to the skin, resulting in ischemic damage and subsequent skin breakdown.[17, 18, 19]

Change Ideas: Strengthen Metabolic Status

- Give patients food/liquid choices to enhance appetite, hydration, and nutrition.
- Provide necessary nutritional supplementation if not contraindicated.
- Generate an automatic consult with the Registered Dietician if a patient is assessed as high risk.
- Consider implementing a standardized process to order a prealbumin level for patients with high risk status.
- Monitor weight, food and fluid intake, and relevant lab test results.
- Provide at risk patients with a water container in a unique color to encourage staff and families to promote ongoing hydration.
- Offer the patient assistance with meals if necessary, and encourage snacks.
- Offer water to the patient during rounds for the 3 "P's" (Pain/Potty/Position).

Suggested Process Measure

- A monthly audit of percentage of high risk patients receiving full pressure ulcer preventative care (daily skin assessment, moisture management, nutrition and hydration optimization, repositioning, use of pressure-redistribution surfaces)[20]

"Hardwiring" Hydration and Nutrition Optimization as part of improvement plan

To hardwire Hydration and Nutrition, make the assessment of patient's nutrition and hydration status routine, with admission assessments as well as with other patient care interventions.

- If a patient is assessed at high risk for a pressure ulcer, an automatic Registered Dietician consult should be generated.

MINIMIZE PRESSURE, SHEAR AND FRICTION

Minimizing the amount of pressure on bony prominences will help to reduce the possibility of breakdown of the thin overlying skin. By repositioning and utilizing pressure-distribution surfaces, pressure on the skin can be redistributed.[21, 22] This is especially critical for patients with limited mobility as they are at high risk for developing pressure ulcers.[23]

Secondary Driver: Turn and reposition patients at least every two hours.

Turning and repositioning a patient helps to redistribute pressure on skin surfaces and maintains circulation to tissues in areas at risk for ulcers.[24] The literature does not provide clear guidelines for turning frequency; however one and one half to two hours in a single position is the maximum amount of time recommended for patients that have normal circulatory function.[25]

Change Ideas: Methods to Reduce Pressure, Shear and Friction

- Repositioning, use of pressure-redistribution surfaces[26]
- Use visual or musical cues, e.g. a turning clock, bells, or alarms at the nurses' station as a reminder to turn and reposition the patient.[27]
- Use visual clues at the bed side to turn the patient, e.g. a turning clock or white board that records the time for the next turn.
- Establish 'rules' for which side a patient should lie on for certain intervals, e.g. even hours on the right side, odd hours on the left side.
- Use pressure-reducing equipment such as beds, mattresses, and foam wedges. Use devices that elevate the heel and prevent external rotation of the ankle and foot.
- Use special beds, mattresses, foam wedges, and pillows (only for limbs) to redistribute pressure on high risk areas.[28]
- Operating room tables should have special overlay mattresses to provide cushioning.[29, 30]
- Use breathable glide sheets and or lifting devices to prevent shear and friction.
- Use a dressing that can be placed on the sacral area to reduce shear and friction (See Appendix IV).
- Use ceiling lifts to encourage patient mobility and movement and prevent work-related injuries among staff.
- Limit layers of linen to no more than 3 (using more than 4 layers has been shown to be an independent risk factor for HAPU). A breathable glide sheet that remains with the bed is much more user-friendly for in-bed mobility, and lifts are better for out-of-bed mobility.

Suggested Process Measure

- A monthly audit of the percentage of high risk patients receiving full pressure ulcer preventative care such as daily skin assessment, moisture management, nutrition and hydration optimization.

Secondary Driver: Develop and institute early mobility/ambulation protocols.

Reduced mobility is a risk factor for the development of pressure ulcers. Putting a process into place that assess a patient's mobility and generates recommendations for physical therapy referral will enable staff to safety mobilize patients. Nurse driven mobility protocols have demonstrated to be effective in reducing immobility related complications and reducing length of stay.[31, 32]

"Hardwiring" Minimizing Pressure in Improvement Plans

Hardwire pressure by making the process as routine as possible and ensuring that all aspects of HAPU prevention are addressed reliably in every patient, every day. Implement protocols for skin evaluation and risk assessment; and for interventions such as repositioning, managing moisture, using of barrier agents, offering toileting and oral fluids, and assessing nutrition, hydration, and mobility. A protocol should also identify those high-risk patients who require additional interventions such as pressure-relieving surfaces and consults with Registered Dietician and Physical Therapy.

POTENTIAL BARRIERS

- Recognize that for many staff these improvements will demand a change in their day-to-day activities. Nurses should be encouraged to embrace the ownership of pressure ulcer prevention as a vital part of their practice. Many nurses appreciate the importance of this critical role in harm prevention.
  - Although pressure ulcers are a "nursing-sensitive condition," physician participation can support these interventions, address medical staff concerns, and help build nursing staff momentum.
  - Traditionally, physicians generated consults to other clinicians; however, these protocols engage nurse members of the team in this role. Lead physicians and champions can build support among the medical staff for these changes for the benefit of the healthcare team's patients.
  - Order sets and protocols may be seen by some physicians or nurses as "cookbook" medicine. A more appealing perspective is to frame them as "best recipe" medicine evidence-based findings to reduce patient risks for HAPU.
- These processes may be considered new territory by many physicians, nurses, nurse aides, physical therapists, and registered dieticians. Nurses may be concerned about making a mistake, being inadequately trained to follow the new policies, or experiencing a hostile work environment from resistant or uncivil medical staff. Education of all stakeholders about the risks of delayed intervention and the efficacy of these improvement efforts can alleviate some of these concerns.

Enlist administrative leadership as sponsors to help remove or mitigate barriers

- A management executive sponsor who recognizes the value for the organization and its patients of preventing HAPU can help brainstorm solutions; contribute helpful resources such as funding, staffing, and supplies; and encourage process adoption. Executive sponsors can provide a "big picture" perspective on the organizational impact of these initiatives, and serve as champions across the organization removing barriers to implementation.
- Respected nurse and physician leaders and champions can promote the adoption of best practice protocols for pressure ulcer prevention. Since these protocols typically involve nursing care without the requirement for physician orders, choose a unit to do a first trial in which the initiative is supported by a receptive nurse lead supported by a physician partnership. A successful trial will demonstrate the benefits of the new protocols and be more easily disseminated to units across the organization.
- Physician and nurse leaders, as well as champions in physical therapy and nutrition, can advocate on behalf of new innovations and address inaccurate perceptions that new protocols are burdensome, difficult, or punitive.

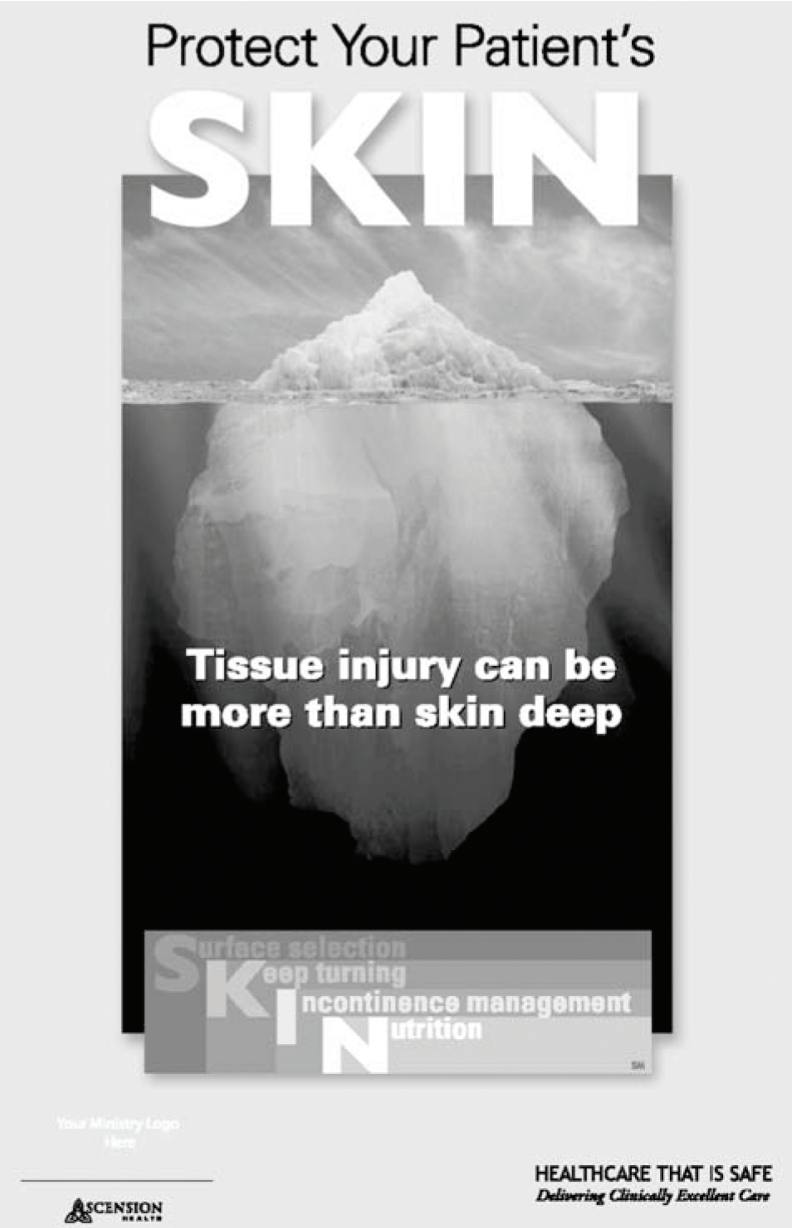
Change not only the practice but the culture

- A change in nursing culture may be necessary; nursing staff will need to embrace the value of their diligent contributions to skin care and harm prevention. Some nurses may be uncomfortable with the idea of a nurse-driven protocol, or with the collaboration demanded not only with physicians, but with physical therapists and registered dieticians. Education and involvement of staff from multiple units and specialties in the development of the protocols may ease concerns and promote multi-disciplinary team cohesion.
- By empowering nursing staff, these innovations may also be of concern to physicians who fear potential negative outcomes for their patients and practices. Many physicians will learn from respected peers rather than from "expert advice." Enlisting physician champions to advocate for these changes and to reassure other physicians about the benefits for patients can be an effective strategy.
- These innovations will require small tests of change; successful trials can then be disseminated across the organization. The ideal outcome is the development and implementation of team-based care in which each member of the team (physician, nurse, nurse's aide, physical therapist, and registered dietician) contributes to improved healthcare quality for patients.

Tips on How to Use the Model for Improvement

- Choice of tests and interventions for HAPU reduction:
  - There are many potentially effective interventions to reduce the risks of HAPU. Improvement teams should begin their efforts by asking: "What is the greatest need at our facility? Where can we have the greatest impact?"
    - Implementation of skin evaluations and risk assessments?
    - Implementation of handoff communications between nurses regarding patient risks and risk mitigation interventions?
    - Redesign of processes to align risk assessment findings with appropriate interventions?
    - Prioritization of interventions based on resources available?
  - Do not wait for "the new beds" or "the new sheets" to arrive to implement prevention strategies. Do small tests of change using the resources available (e.g. turning patients every 1-2 hours, optimizing nutrition, improving handoff communications), and then upgrade the processes/ equipment/technology over time.
- Implement small tests of change:
  - Step 1: Plan – Choose a risk assessment tool.
    - Choose an established evidenced-based practice tool such as the Braden Skin Risk Assessment Tool. Choose one or two tools to test and solicit staff feedback on ease-of-use and effectiveness.
  - Step 2: Do – Keep the scale of an initial test small. Begin with one nurse, on one shift. Then test with a few more nurses of varying experience levels and a small number of patients.
  - Step 3: Study – Evaluate tool ease-of-use and effectiveness with the staff members that tested the tool. Which tool was easiest to use and provided assessment findings that could be incorporated into the care plan?
  - Step 4: Act – Skin risk assessment documentation flowsheets may need to go through several "tweaks" before they are ready to use on a wider scale.
    - Know when to stop a test. If the test results show that a change is not leading to improvement, then stop the test, and try a different test.
- Implement a Nursing Protocol to turn patients at least every two hours
  - Step 1: Plan – Decide which unit and shift will launch the small tests of change, opting to enlist nurses who are willing to attempt the trials. Seek out nurse champions and early adopters.
  - Step 2: Do – Test the nursing protocol to turn patients at least every two hours.
    - Start "simple" – one unit, one shift, one process.
  - Step 3: Study – Debrief with the participating staff at the end of each shift to evaluate the results of the process.
- Ask questions such as, "What worked well?", "What did not work well?", and "What do we need to change for the next test?"
  - Step 4: Act – Implement learning from tests as soon as possible. Retest on the same unit, with the same staff, on the next day. Repeat until the process is successful and then disseminate the trial to other shifts or units.

Appendix I: Educational Poster[33]



Appendix II: Clipboard reminder for patients at risk of pressure ulcers[34]

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 up in 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.

Not a permanent part of the medical record

Appendix III: Skin Bundle Compliance Tool[35]

			Patient Identifier
			Braden Score < 18
			LOS < 24 Hours
			S Surface Type
			K Turing documented every 2 hours
			K Heels off bed documented
			I Incontinence care documented
			N Nutritionally at risk
			N Nutritional consult completed
			N Nutritional orders written
			N Nutritional orders carried out
			Comments

Appendix IV: Example of Sacral Dressing to Reduce Shear & Friction

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