SKIN INTEGRITY DECISION TREE

PATIENT ADMITTED TO McLAREN FLINT

RN to complete Skin assessment and Braden assessment upon admission

SCORE >18 WITHOUT WOUND

- Skin assessment every 12 hours
- Braden assessment every 12 hours

SCORE >18 WITH WOUND

- Skin assessment every 12 hours
- Braden assessment every 12 hours
- Wound assessment with each dressing change – Measure wounds upon identification and weekly on Wednesday
- Treatment – Follow Instructions in Wound Care Manual
- If incontinent, apply barrier cream/wipe
- If albumin <3.0, order dietary eval
- Initiate Skin Integrity IPOC
  - Document on IPOC q shift
  - Document patient/family education q shift

SCORE <18 WITHOUT WOUND

- Skin assessment every 12 hours
- Braden assessment every 12 hours
- Place patient on support surface mattress/bed
- Every two hours **TURNING** if patient is unable to reposition self
- If incontinent, apply barrier cream/wipe
- If albumin <3.0, order dietary eval
- Consider heel elevation boots and document
- Place sacral foam dressing on sacrum and document

SCORE <18 WITH WOUND

- Skin assessment every 12 hours
- Braden assessment every 12 hours
- Place patient on support surface mattress/bed
- Every two hours **TURNING** if patient is unable to reposition self
- Wound assessment with each dressing change – Measure wounds upon identification and weekly on Wednesday
- Treatment – Follow Instructions in Wound Care Manual
- If incontinent, apply barrier cream/wipe
- If albumin <3.0, order dietary eval
- Initiate Skin Integrity IPOC
  - Document on IPOC q shift
  - Document patient/family education q shift
- Consider heel offloading boots and document
- Place sacral foam dressing on sacrum if no sacral wound present and document

Appendix B revised bw, 2016, revised 8/20, revised 6/22 blw, 8/22 blw