

## McLaren Print System Order

Order No: 73800  
 Order Date: 2022-11-23  
 User: Angie Rigda  
 Phone: 22031

Ship Location: McLaren Flint - ICU Angie Rigda  
 401 S Ballenger Highway  
 Flint, MI 48532

Brochures  
 Quantity: 30  
 Paragon Dept No: 30190  
 Dept Name: ICU  
 Company Number: 60

Order Total Price: 75.00

Item Number: M-1513  
 Item Description: Skin Integrity Decision Tree - CLING  
 Revision Date: 10/2022  
 Print:  
 Paper:  
 Size:  
 Fold:  
 Finish:  
 Drill:  
 Poster:  
 Misc Info: cling, 8.5x11, ss, no bleed, color

## SKIN INTEGRITY DECISION TREE

PATIENT ADMITTED TO McLAREN FLINT

RN to complete Skin assessment and Braden assessment upon admission

SCORE >18 WITHOUT WOUND	SCORE >18 WITH WOUND	SCORE <18 WITHOUT WOUND	SCORE <18 WITH WOUND
<ul style="list-style-type: none"> <li>■ Skin assessment every 12 hours</li> <li>■ Braden assessment every 12 hours</li> </ul>	<ul style="list-style-type: none"> <li>■ Skin assessment every 12 hours</li> <li>■ Braden assessment every 12 hours</li> <li>■ Wound assessment with each dressing change – Measure wounds upon identification and weekly on Wednesday</li> <li>■ Treatment – Follow Instructions in Wound Care Manual</li> <li>■ If incontinent, apply barrier cream/wipe</li> <li>■ If albumin &lt;3.0, order dietary eval</li> <li>■ Initiate Skin Integrity IPOC                             <ul style="list-style-type: none"> <li>– Document on IPOC q shift</li> <li>– Document patient/family education q shift</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Skin assessment every 12 hours</li> <li>■ Braden assessment every 12 hours</li> <li>■ Place patient on support surface mattress/bed</li> <li>■ Every two hours <b>TURNING</b> if patient is unable to reposition self</li> <li>■ If incontinent, apply barrier cream/wipe</li> <li>■ If albumin &lt;3.0, order dietary eval</li> <li>■ Consider heel elevation boots and document</li> <li>■ Place sacral foam dressing on sacrum and document</li> </ul>	<ul style="list-style-type: none"> <li>■ Skin assessment every 12 hours</li> <li>■ Braden assessment every 12 hours</li> <li>■ Place patient on support surface mattress/bed</li> <li>■ Every two hours <b>TURNING</b> if patient is unable to reposition self</li> <li>■ Wound assessment with each dressing change – Measure wounds upon identification and weekly on Wednesday</li> <li>■ Treatment – Follow Instructions in Wound Care Manual</li> <li>■ If incontinent, apply barrier cream/wipe</li> <li>■ If albumin &lt;3.0, order dietary eval</li> <li>■ Initiate Skin Integrity IPOC                             <ul style="list-style-type: none"> <li>– Document on IPOC q shift</li> <li>– Document patient/family education q shift</li> </ul> </li> <li>■ Consider heel offloading boots and document</li> <li>■ Place sacral foam dressing on sacrum if no sacral wound present and document</li> </ul>

Appendix B Revised Dec. 2016, revised 8/22, revised 8/22 Dec. 8/22 Mar M 1513 10/22

Spec Info: