

SKIN BREAKDOWN GUIDE

Complete at time of skin breakdown:

- _____ 1. Measure wound and initiate wound progress report
- _____ 2. Notify Dr. and obtain treatment according to facility protocol
- _____ 3. Notify family/guardian of wound and tx plan
- _____ 4. Request dietary consult
- _____ 5. Notify MDS nurse
- _____ 6. Repeat pressure ulcer risk assessment per policy
- _____ 7. Assess contributing factors and initiate appropriate interventions
- _____ 8. Increase frequency of weights as indicated
- _____ 9. If diabetic review BS and f/u accordingly
- _____ 10. Review if vitamin, zinc or vitamin C is needed
- _____ 12. Communicate to staff changes in residents' plan of care and update CNA/bedside care plan
- _____ 13. Initiate temporary care plan or update existing care plan with steps taken and interventions

Interventions to consider:

- _____ 1. Turning schedule (review and update as indicated)
- _____ 2. Incontinence program (review and update as indicated)
- _____ 3. Positioning devices
- _____ 4. Support surface for bed
- _____ 5. Support surface for chair
- _____ 6. Heel/elbow protectors if friction is a problem
- _____ 7. Elevate heels off bed
- _____ 8. Fortified foods (increased nutrients/calories)
- _____ 9. Supplements
- _____ 10. Lab work – albumin, electrolytes, WBC, H&H – as indicated
- _____ 11. Increase assistance with meals
- _____ 12. Increase fluids
- _____ 13. Multivitamin, vitamin C, zinc as indicated

Goal: ___ Wound will heal within 2 weeks
_____ Wound will not decline over next 2 weeks
_____ Other _____

Resident Name _____ Room _____

Medical Records _____ Physician _____

Nurse Signature _____ Date _____

