

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 responsible party of wound and tx plan
- 4. Notify dietary
- 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
- 11. Review intake/nutritional status and determine if nutritional supplements are 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 of steps taken and interventions

Interventions to consider:

- Positioning program (review and update as indicated)
- Incontinence program (review and update as indicated)
- Positioning devices
- Support surface for bed
- Support surface for chair
- Heel protectors
- Elbow protectors
- Increase frequency of baths
- Fortified foods (increased nutrients/calories)
- Supplements
- Lab work – albumin, electrolytes, WBC, H&H – as indicated
- Increase assist with meals
- Increase fluids
- I&O, f/u accordingly
- 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 Record # _____ Physician _____
Date _____ Nurse Signature _____



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