**Community SSKIN Bundle**

Patient label

|  |  |
| --- | --- |
|  | Information given to patient/ carer Y Npressure ulcer leaflet given to patient/ carer Y NDATE:Name:Designation: |

|  |  |
| --- | --- |
| **S** | **SURFACE** |
| provide a mattress and cushion in accordance with the waterlow and clinical judgement |
| Mattress ordered:  | Date ordered: | Date delivered + fitted: |
| Cushion ordered: | Date ordered: | Date delivered:  |
| Other (state item) | Date ordered: | Date delivered:  |
| Wheelchair user Y N if yes, is a pressure reducing cushion in use? Y N |
| **S** | **SKIN INSPECTION** |
| **Assess** and record skin state on each visit **Carry** out assessment of red area of skin (erythema) blanching yes/no**Record** the skin as follows and ensure location is recordedNo evidence of *new* pressure damage, blanching erythema/ category 1/ category 2/ category 3/ category 4 |
| **Record frequency of skin assessment-** circle one; daily/twice weekly/ weekly/ monthly/ 3 monthly |
| **K** | **KEEP MOVING** |
| Record current regime of movement |
| Morning | afternoon |
| Evening | Night |
| Repositioning regime advised: |
| Method of transfer: |
| **I** | **INCONTINENCE** |
| **assess** continence state**assess** if the patients skin is prone to moisture |
| is the patient incontinent of urine Y N Faeces Y N Double Y N |
| **N** | **NUTRITION and HYDRATION** |
| Ensure the **must** score is completed on the initial assessment and reassessed in line with **MUST** guidance |
| **MUST Score:** | **review date of MUST:** |

|  |  |
| --- | --- |
| **Patients name:** | NHS number: |
| Date: |  |  |  |
| Time: |  |  |  |
| **SURFACE** |  |  |  |
| Is the mattress in use? | Y N | Y N |  Y N |
| is the cushion in use? | Y N | Y N | Y N |
| Is other (state)………in use? | Y N | Y N | Y N |
| Is equipment working correctly? | Y N | Y N | Y N |
| Is patient comfortable? | Y N | Y N | Y N |
| If NO to any of the above please add additional information |
| **SKIN INSPECTION** |
| is there evidence of pressure damage to; |
| Buttocks (ischial bones) | Y N | Y N | Y N |
| Elbows | Y N | Y N | Y N |
| Sacrum | Y N | Y N | Y N |
| Trochanter (hips) | Y N | Y N | Y N |
| Spine | Y N | Y N | Y N |
| Heels | Y N | Y N | Y N |
| Occiput | Y N | Y N | Y N |
| Toes | Y N | Y N | Y N |
| Other please state | Y N | Y N | Y N |
| If YES to any of the above please add additional information  |
| **KEEP MOVING** |
| Is current repositioning regime being adhered to according to patient/ carer? | Y N | Y N | Y N |
| Is the current regime effective | Y N | Y N | Y N |
| If NO please add additional information |
| **INCONTINENCE/ MOISTURE** |
| Is the skin moist? | Y N | Y N | Y N |
| Had a continence assessment | Y N | Y N | Y N |
| If YES please provide additional information |
| **NUTRITION** |
| Is the patient eating and drinking adequately? | Y N | Y N | Y N |
| Signature and print name |  |  |  |