**Community SSKIN Bundle**

Patient label

|  |  |
| --- | --- |
|  | Information given to patient/ carer Y N  pressure ulcer leaflet given to patient/ carer Y N  DATE:  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 recorded  No 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 |  | | |  |  |