Checklist and Communication Tool for Patients, Carers, Relatives and Healthcare Professionals

The checklist chart is provided separately. It helps you to keep the person you care for free from developing pressure ulcers

The chart is divided into sections:

Complete each section as directed by your healthcare professional. See the SSKIN assessment instructions for an explanation of the different areas to check.
If any applicable section does not receive a ✓ please tell us.

Your contact is:

Signature List

To be completed by Healthcare Professionals/ Carers/Relatives and Patients

Print name	Signature	Initials	Designation

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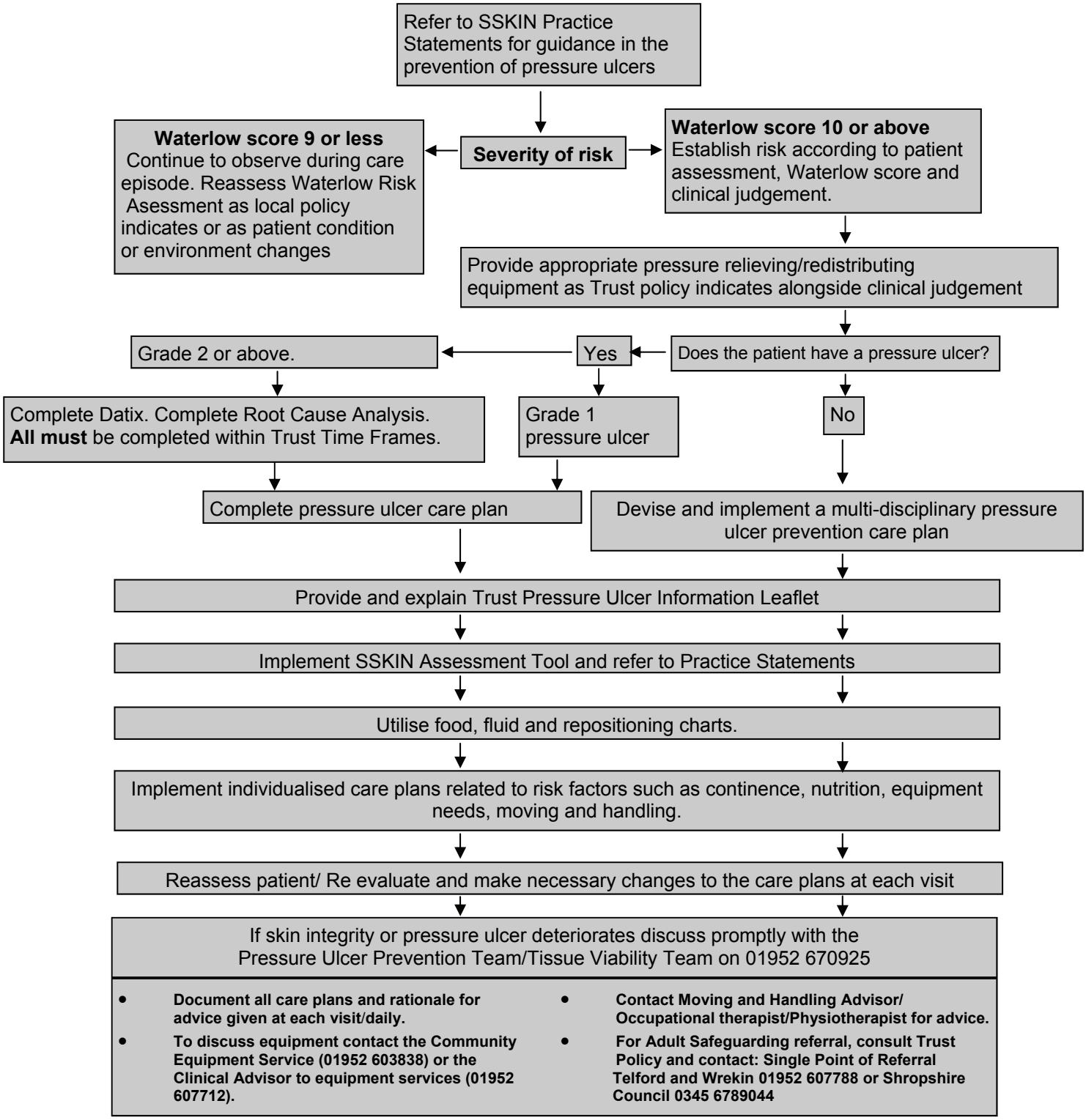
Care pathway for healthcare professionals: Prevention and Management of Pressure Ulcers

All patients to be screened for risk of developing a pressure ulcer using Waterlow Risk Assessment Tool. Community Hospital within six hours of admission/Community nursing on initial visit. Complete Waterlow Risk Assessment at least weekly on all at risk patients, or more often if patient condition changes. Make nutritional assessment as directed by Waterlow risk assessment and clinical judgement.



- **Document all care plans and rationale for advice given at each visit/daily.**
- **To discuss equipment contact the Community Equipment Service (01952 603838) or the Clinical Advisor to equipment services (01952 607712).**
- **Contact Moving and Handling Advisor/ Occupational therapist/Physiotherapist for advice.**
- **For Adult Safeguarding referral, consult Trust Policy and contact: Single Point of Referral Telford and Wrekin 01952 607788 or Shropshire Council 0345 6789044**

Think..... SSKIN

Pressure Ulcer Prevention
Risk and Action Flowchart for Carers

At Risk

- Can change position without help or prompting
- Has a good appetite
- Has no acute health problems
- Continent or managed with appropriate devices

↓

Complete SSKIN Assessment Tool on each visit.
Observe individual for change in condition / environment and contact the appropriate health professional as detailed below.

High Risk

- Has reduced mobility or requires prompting to move
- Has a reduced fluid intake
- Has a reduced appetite
- Occasional incontinence

↓

Reduced mobility or requires prompting to move, devise repositioning schedule and record on a repositioning chart
Reduced fluid intake record and monitor on a daily fluid chart
Reduced nutritional intake or change in appetite record and monitor on a daily food diary
Refer for continence assessment

Very High

- Unable to change position without help or prompting
- Has persistent incontinence
- Has a poor appetite
- Has poor general health

↓

Regular repositioning required, devise repositioning schedule and record on a repositioning chart.
Record and monitor fluid input and output on a daily fluid chart.
Record and monitor nutritional intake on a daily food diary.
Refer for continence assessment

- **If any concerns please contact the District Nurse/ GP/ Tissue Viability/ Pressure Ulcer Prevention Team/Shropdoc.**
- **If concerned the individual is acutely unwell contact GP/Shropdoc immediately. In a medical emergency dial 999.**

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SSKIN Assessment Instructions

If each individual criteria is met then mark with a ✓ on SSKIN Assessment Tool. If a ✘ is received record on action/variance chart with the actions taken and **tell us**. If not applicable to the episode of care record as N/A.

Best practice indicates SSKIN Assessment Tool must be completed at each patient contact.
If following patient assessment/clinical risk assessment and clinical judgement this is not appropriate for the patient, please document frequency of the SSKIN assessment and give clear rationale in pressure ulcer prevention care plan.

Surface

If the equipment is made of foam

✓Cover is intact
✓Foam is flat and smooth
✘ If the cover is ripped or torn……**tell us**
✘ If there is a dip in the foam……**tell us**

If the equipment is air based

✓Cover is intact
✓ Equipment is inflated
✓ You cannot hear the alarm
✘ If the cover is ripped or torn……**tell us**
✘ If the equipment is not inflating…..**tell us**
✘ If the alarm is sounding……...**tell us**

Skin inspection

Check all the areas listed

✓Skin is not discoloured, broken or painful
✓ If pressure ulcer dressing is dry and intact
✘ If skin is discoloured, broken or painful……..**tell us**
✘ If pressure ulcer dressing is wet or not intact……**tell us**

Keep moving

✓ Position changed as per care plan
✓ Independent or fully mobile
✘ Individual hasn't changed position within recommended time plan……**tell us**

Incontinence

✓Skin washed and dried at least daily and when visibly soiled
✓Barrier preparation applied
✓Well-fitting continence products/equipment being used
✘ Skin not cleansed and dried……**tell us**
✘ Barrier preparation not applied……..…..**tell us**
✘ Inadequate continence products/equipment used ……..**tell us**

Nutrition & hydration

✓ Drink taken
✓ Food taken
✓Supplement drink taken (if prescribed)
✘ If the patient has reduced fluid intake for 24 hours ……..**start a fluid chart and tell us**
✘ If the patient has a reduced appetite for three days ……..**start a food chart and tell us**

If any concerns please contact the Healthcare Professional on the front cover or District Nurse/ GP/ Tissue Viability Nurse/Pressure Ulcer Prevention Team/Shropdoc.
If concerned the individual is acutely unwell contact GP/ Shropdoc immediately.
In a medical emergency dial 999.

Think..... SSKIN

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

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SSKIN Assessment Tool

Frequency :

Page:

Use a ✓if criteria met or a ✖ if not (record reasons why on the action chart), or N/A if not applicable.
Level of risk: If using waterlow risk assessment write score. Alternatively use At Risk ; (AR), High Risk (HR), Very High Risk (VHR).

Date								
Time								
Level of risk (specify)								
Surface								
Mattress								
Cushion								
Other								
Skin Inspection								
Right hip								
Left hip								
Right heel								
Left heel								
Right ankle								
Left ankle								
Base of spine								
Right elbow								
Left elbow								
Right buttock								
Left buttock								
Other								
Keep Moving								
Position changed								
Incontinence								
Skin cleansed								
Barrier preparation								
Continence product/ equipment								
Nutrition and hydration								
Food taken								
Drink taken								
Supplement								
Signature								

Think..... SSKIN

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Page:

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Action Chart for Patients, Carers and Relatives

If an X is used on the SSKIN Assessment Tool please provide details and action taken on the chart below

Date and time	Reason for X	Action taken and who contacted	Signature

Think..... SSKIN

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Page:

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Variance Chart for Healthcare and Allied Healthcare Professionals

If an X is used on the SSKIN Assessment Tool or there is a variance from the agreed care plans please provide details and action taken on the chart below

Date and Time	Variance	Action Taken	Signature

Think..... SSKIN