Basic Skin Care Plan for Patient or Resident	(name

PROBLEM	GOAL	INTERVENTIONS — check box (✓) or highlight applicable interventions.	Date	Initia
Pressure, Shear, Friction	Decrease Pressure,	☐ Check heels and bony prominences daily for redness or 'mushy' feeling.		
	Shear, Friction	☐ Avoid massage over bony prominences.		
		☐ Avoid positioning directly on trochanter e.g., full side lying position.		
		☐ Use pillows or foam to separate knees when patient is side lying.		
		☐ Keep HOB < 30° unless eating or contraindicated.		
		☐ Assess transfer and repositioning techniques for possible shearing.		
		☐ Check all seating surfaces for inappropriate surface contact and duration of time sitting. E.g., commodes with sharp edges or non-padded seats.		
		☐ Avoid constant angle changes in the bed or recliner as this creates shearing along the spinal processes and ischial tuberosities		
		☐ Raise heels off bed using pillows or foam under calf or heel boots / Hollister Roho / foam foot cradles. Do not use Spenco or sheepskin boots.		
		□ Protect elbows, heels, sacrum if exposed to friction. Strategy:		
		☐ Refer to OT or PT for seating, positioning and mattress assessment and care plan recommendations.		
		☐ Follow recommendations of the therapists.		
	Appropriate Mattress Selection (SIRA Score)	For high risk patients (10-12) Use a preventative mattress: □ Type of Mattress □ Type of Mattress □ Type of Mattress □ Type of Mattress		
	Appropriate Turning Schedule	Use trapeze, if indicated, or turning sheet or overhead positioning sling for all position changes.		
		For mild risk patients (15-18) or moderate risk (13-14), turn no less than <u>every 4 hours</u> with turning sheet or positioning sling.		
		☐ For high risk patients (10-12) or very high risk (≤ 9) turn <u>every 2 hours</u> with a turning sheet or positioning sheet if not on a therapeutic mattress, otherwise turn <u>every 4 hours</u> if on a therapeutic mattress.		
		Additional Strategies or Comments:		

Urinary & Fecal Incontinence	Manage Moisture	 □ Provide peri-care after each incontinent episode or when the brief is changed. □ Avoid talc, cornstarch, or hot water during peri-care. □ Moisturize dry skin. □ Use recommended disposable pads on the therapeutic mattresses. □ Use commercial moisturizer. Type:	
Impaired Nutritio Status	Improved Nutrition	 Review weight history. Assess intake daily according to Canada's Food Guide and protein servings (Meat or Dairy Products). Refer to Dietitian. Date referral made: Ensure fluid intake is ≥ 1500 ml / day or 25 ml / kg body weight / day. Increase kilocalories in diet to 25- 35 kcal / kg body weight / day to promote wound healing, depending on nutritional goals and if patient is underweight/obese and euglycemia. Recommend a vitamin/mineral supplement Zinc supplementation (25 – 50 mg/d) with Stage 3 or 4 pressure ulcers or excessive GI losses, smokers need an additional 35 mg/d of vitamin C. Protein intake is 1.0 - 1.5 grams / kg body weight / day. □ Increase protein to 2.0 grams/kg/day for deep or draining ulcers. Additional Strategies or Comments: (e.g., consider sodium restriction with edema) 	
Impaired Sensory Perception	Manage Effects of Deficits in Sensory Perception	 ☐ Manage underlying disease e.g., diabetes. ☐ Avoid constrictive applications such as improperly applied dressings, tensors, stockings and orthotics. ☐ Avoid tight shoes. ☐ Avoid snug-fitting bed sheets, especially over the feet. ☐ Use foot cradle ☐ Raise heels off bed using pillows or foam under calf. Additional Strategies or Comments: 	
Pain	Manage Pain	□ Develop pain management care plan. □ Use therapeutic mattress for severe pain or pain exacerbated by turning. Type: Additional Strategies or Comments:	