File within 3rd spine

Place patient sticker **within** this box

NHS
Royal Cornwall Hospitals
NHS Trust

Skin bundle assessment

Ward: _____

The following chart guides staff on the frequency of SKIN bundle assessment

Daily (At risk)	Twice daily (High risk)	Three or more times daily (Very high risk)
Requires occasional assistance with mobility	Reduced mobility / needs help with mobility / repositioning	Bed or chair bound / unable to move without assistance
Occasional incontinence	Incontinence more than once a day	Doubly incontinent
Vulnerable dry skin	Moist skin from pyrexia or sweating	Existing or healed pressure ulcer or non-blanching erythema (Grade 1)
	Nutritionally compromised / Nil by Mouth / Recent weight loss	Reduced skin perfusion due to low BP, or dehydration
	Underlying medical conditions ie: Diabetes, Vascular disease, Cardiac failure	Significant deterioration in underlying condition causing neuropathy, reduced blood flow, pain or oedema
	Recent surgery within last 48 hours	Recent lower limb surgery within last 48 hours
		Increased risk of shearing / friction
		End of life care (consider increasing frequency if skin deteriorates)

Assess patient on admission, and re assess on transfer to another clinical area or if condition changes and prior to discharge.

Date of assessment / re-assessment	Record frequency of skin assessment	Signature

Continued overleaf...

Place patient sticker **within** this box

Date Time						
Skin inspection	**Y / N**	**Y / N**	**Y / N**	**Y / N**	**Y / N**	**Y / N**
All vulnerable skin areas checked						
Pressure damage present? Y / N						
Category of pressure damage (see guide below)						
Site of pressure damage:						
Is there evidence of moisture related skin damage?						
If NEW pressure ulcer present or category has changed, has category been validated by a RN / AP?						
Surface						
Air mattress						
Hybrid mattress						
Static foam mattress						
Cushion						
Heel protection						
Keep moving / Repositioning plan						
1 – 2 hourly						
2 – 4 hourly						
4 – 6 hourly						
Independent						
Incontinence						
Urinary incontinence						
Faecal incontinence						
Nutrition						
Nil by Mouth						
Reduced appetite						
Normal eating						
Initials						

Category 1
Unbroken skin
Area of red or discoloured tissue that does not blanch when pressed with finger tip

Category 2
Shallow area of broken skin or blister. May have a thin layer of slough that is easily removed

Category 3
Deeper area of broken skin
May be completely covered in thick slough but bone and tendon are not exposed

Category 4
Deep cavity where bone and tendon is exposed and undermining
Hard necrotic tissue may indicate deep damage.

Unstageable – Full thickness skin loss. The depth is unable to be confirmed due to presence of eschar / slough.
Suspected deep tissue injury – Purple / discoloured area of skin that is 'boggy' and painful. May progress to deeper damage.
Device related pressure ulcer - annotate with a (d) ie Cat 2 (d)