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| --- | --- | --- |
| Patient Name: | Hospital Number: | Ward: |
| A pressure ulcer risk assessment has been completed and identified the above patient to be (circle); at risk / moderate risk / high risk / very high risk of skin injury caused by pressure. Based on the risks identified, clinical judgement and discussion/s with the patient, the frequency of pressure ulcer prevention care will be determined, and the provision of additional prevention will be provided where appropriate. Renew plan once the aSSKINg provide care sheet full and/or update under any changes (below). | | |

 **aSSKINg Patient Care Plan**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date:  Time care plan started:  Braden sore: | | | | Additional plan i.e., maximum time in chair, pain management before transfer/repositioning. | **Any changes to previous plan or risk score status, complete new care plan below** | | | | |
| Date:  Time care plan started:  Braden sore: | | | | Additional plan i.e., maximum time in chair, pain management before transfer/repositioning. |
| **Planned frequency of care (tick)** | 1-2 hours | 2-3 hours | 3-4 hours | **Planned frequency of care (tick)** | 1-2 hours | 2-3 hours | 3-4 hours |
| **Day** |  |  |  | **Day** |  |  |  |
| **Night** |  |  |  | **Night** |  |  |  |
| Appropriate mattress- The patient requires i.e., foam/air | | | | | Appropriate mattress- The patient requires i.e., foam/air | | | | |
| Appropriate chair cushion – The patient requires i.e., foam/air | | | | | Appropriate chair cushion – The patient requires i.e., foam/air | | | | |
| Additional heel off-loading device requirement i.e., pillows/air boots/air wedge? | | | | | Additional heel off-loading device requirement i.e., pillows/air boots/air wedge? | | | | |
| A moving and handling slide sheet is required to prevent friction Y N  An additional sliding sheet is needed for heels Y N | | | | | A moving and handling slide sheet is required to prevent friction Y N  An additional sliding sheet is needed for heels Y N | | | | |
| Continence products required (circle) incontinence pads / foam skin wash / barrier film spray / barrier cream / soap substitute emollient, other (state): | | | | | Continence products required (circle) Incontinence pads / foam skin wash / barrier film spray / barrier cream / soap substitute emollient, other (state): | | | | |
| Following the Braden risk assessment and MUST; If the patient’s nutritional requirements have been identified as a risk; has a dietitian referral been sent? Y N | | | | | Following the Braden risk assessment and MUST; If the patient’s nutritional requirements have been identified as a risk; has a dietitian referral been sent? Y N | | | | |
| Has the patient been prescribed nutritional supplements? Y N | | | | | Has the patient been prescribed nutritional supplements? Y N | | | | |
| Tick box to confirm the aSSKINg care plan has been explained and discussed with the patient and/or family/carer (where appropriate)? □ | | | | | Tick box to confirm the aSSKINg care plan has been explained and discussed with the patient and/or family/carer where appropriate? □ | | | | |
| Print name and signature of RN completing care plan: | | | | | Print name and signature of RN completing care plan: | | | | |

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| --- | --- | --- | --- |
| **Key:** | **OW** – Off Ward | **R** - Refused | **TH** – With Therapist |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Time:** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surface - appropriate provision and function | | | | | | | | | | | | | | | | | | | | | | | | |
| Mattress appropriate (state type Foam/Air) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Cushion appropriate (state type) Foam/Air | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Confirm heels are offloaded (tick when checked) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Functionality/integrity check of equipment performed (tick when checked) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Skin Inspection – tick when pressure areas checked – record N if no damage present, or Y and document on body map (Remove devices to allow inspection)** | | | | | | | | | | | | | | | | | | | | | | | | |
| All pressure areas checked | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Any existing and/or new redness/discolouration/skin tone change i.e. soft/firm over pressure ulcer site | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Keep moving – tick which position patient is in when encouraged/assisted to move** | | | | | | | | | | | | | | | | | | | | | | | | |
| Bed | Right side (30˚ tilt) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Left side (30˚ tilt) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Back |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Chair | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Incontinence – tick if patient has been incontinent and received continence care** | | | | | | | | | | | | | | | | | | | | | | | | |
| Urine – skin has come into contact with urine and continence care has been given | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bowels – skin has come into contact with faeces and continence care has been given | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Nutrition – tick when checked** | | | | | | | | | | | | | | | | | | | | | | | | |
| Diet (please state i.e. NBM, NG) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Fluids (please state i.e. IVF) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Supplement(s) (please state) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Initials/Signature** You are signing to confirm the above care  has been delivered at the time specified | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**aSSKINg Provided Care**