

Daily Skin Care Flow Sheet

Date: _____

This flow sheet is completed by the RN for all patients with a Braden Score < 19, to document presence of wound and any dressing, and identify interventions applicable to the patient.

If intervention not applicable to the patient indicate by N/A in the appropriate column.

Positioning schedule if applicable: Place code in box and initial to indicate activity in the box closest to the applicable time.

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Activity																								
Initials																								
Activity																								
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R = Right Side L = Left side P = Prone S = Supine C = Chair B = Bed BH = Bridge Heels

Mild Risk Score 16 – 18

Intervention	7a – 7p initial	7p – 7a initial
Keep skin clean & dry / moisturize dry skin		
Encourage appropriate nutrition / fluid intake		
Protect skin from moisture / incontinence		
Decrease friction & shear		
Maximize remobilization		
Implement positioning schedule / float heels on pillows, if applicable		
If paralysis, pneumonia, hip fx., or age >75 years, advance to next level		

Moderate Risk Score 13 – 15

All previous intervention plus:	7a – 7p initial	7p – 7a initial
Pressure reduction mattress or chair cushion if patient is bed-bound or chair-bound (initial if support surface is in use)		
Turning schedule with "30-degree rule."		
Consult Wound / Ostomy / Continence Nurse (date consulted: _____)		

High Risk Score < 13

All previous intervention plus:	7a – 7p initial	7p – 7a initial
Consider low-air-loss bed (initial if bed is in use)		

- Consult with Wound Nurse? Yes N/A • Does patient have skin breakdown / pressure ulcers? Yes No
- Nutrition Supplement? Yes N/A • Consult with Dietitian? Yes N/A

(see back page to document dressing changes and pharmacological treatments)

• Is the breakdown new? Yes N/A If yes, physician notified: _____
Physician name RN Signature–date / time

If patient is being transferred / discharged out of the hospital:

• Has discharge photo been taken of the wound / skin breakdown? (within 48 hours) Yes N/A
 If yes, name of receiving facility / unit / family aware of the wound / skin breakdown. Name: _____

Signature / Title	Date / Shift	Signature / Title	Date / Shift
Signature / Title	Date / Shift	Signature / Title	Date / Shift

PATIENT IDENTIFICATION



SKIN CARE FLOW SHEET

9095

