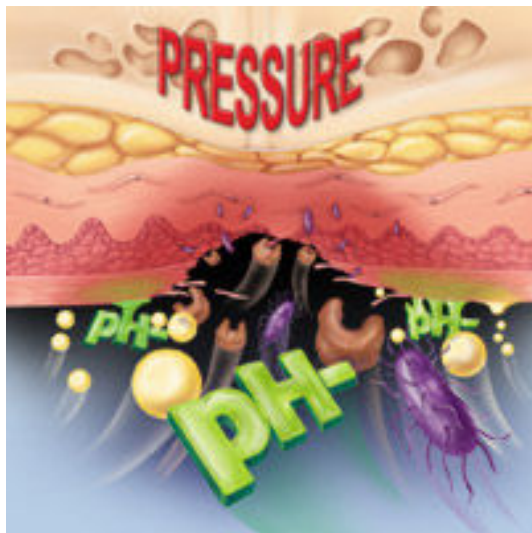


I is for Incontinence / Moisture Management

I: Incontinence / Moisture Management		
Value Range for Row		
Back	Next	Clear
PROMPTED VOIDING		
ABSORBENT UNDERPAD IN PLACE		
APPLIED MOISTURE BARRIER OINTMENT/CREAM		
APPLIED SKIN BARRIER FILM/MPE		
URINARY CONTAINMENT DEVICE IN PLACE		
FECAL CONTAINMENT DEVICE IN PLACE		
LINENS CLEAN DRY, WRINKLE-FREE		
Back	Next	Clear
Last Filed Value		
No data filed		

- 1 Urinary containment = Indwelling catheter or condom catheter
- 2 Fecal containment = Flexi-seal, rectal tube

NOTE: Diaper ≠ urinary or fecal containment
(for the purposes of the SKIN Bundle)



N is for Nutrition

N: Nutrition		
Value Range for Row		
Back	Next	Clear
NUTRITION SERVICES CONSULT OBTAINED		
ENCOURAGED FOOD INTAKE		
ENCOURAGED SUPPLEMENT INTAKE		
ENCOURAGED FLUID INTAKE		
MONITORED RELEVANT LAB VALUES		
MONITORED WEIGHT		
Back	Next	Clear
Last Filed Value		
No data filed		

This field is for documentation purposes ONLY. No referrals are sent out from your documentation on the flowsheet. **The process to get a Nutrition referral at admission is as follows:**

- ◆ If your patient has a Pressure Ulcer and/or a Braden score of 18 or less, the patient needs ancillary referrals.
- ◆ When you get to Part C of the Admission Assessment (also known as "Alerts!"), there is a section about WOUNDS:

wounds? [SSC WOUND ALERT IP NCAL:50677: "None"]

None

Braden Score is <= 18

ANY Pressure Ulcer - Stage II and Greater Large Non-Healing Wound(s)

- ◆ Selecting any of the above options will cause this pop-up window to appear:

Initial Assessment Alerts

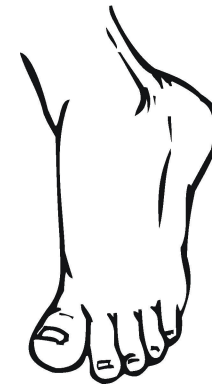
Send a referral alert to both wound care specialist and nutritional services?

Yes No

- ◆ Select YES and a similar pop-up window will appear stating that a referral has been sent to both WOCN and Nutrition.

NOTE: If the Braden Score changes to at-risk after admission, please call the MD for any referrals.

SKIN Bundle Documentation



SKIN BUNDLE KEY POINTS:

- Braden Score is done EVERY SHIFT (not daily, like before...)
- If the SKIN Bundle is "populated" in your Shift Assessment Flow sheet, you must document on your interventions EVERY SHIFT.

WOUND IP NAT'L KEY POINTS:

- Pressure Ulcers are staged, measured and photographed:
 - Upon admission/discovery
 - Then once a week until discharge
 - Again at discharge

