SKIN DOCUMENTATION

04/09/2021

4/13/21 PUR team cy

1. RISK ALERTS PRESENT ON ADMISSION

Risk Alerts Present on Admission		C	SC	ONADM	6 hrs

ıies

Document Present on admission

Fri, Apr 9, 2021 1005 by Carolynn Young

PATIENT ON ADMISSION WITH:

Risk Alerts present on Admission:	☐ Foley Catheter ☐ Wound ☐ Pressure Ulcer ☐ Adult Diaper ☐ Neg Pressure Wound Device ☐ Ostomy ☐ PICC Line ☐ CVAD ☐ Braden Score 18 or less ☐ None
	CVAD includes any of the following: Midline, Hickman Broviac, Infusaport, Triple Lumen(Subclavian), Single/Double/Triple Lumen, Groshong, Arterial, Shiley, Quinton, PICC, Femoral, Intraosseous, Adjunct Internal Jugular

2. PRESSURE INJURY/ULCER UPON ADMISSION (Currently in HxDB ADM:Physical -- Med/Surg)

MANDATORY PRESSURE POINTS EVALUATION	
OCCIPITAL SCALP - Skin intact/without redness?	○ Yes ○ No
POST AURICULAR - Both intact/without redness?	○ Yes ○ No
SCAPULA - Both intact/without redness?	○ Yes ○ No
ELBOWS - Both intact/without redness?	○ Yes ○ No
TROCHANTER - Both intact/without redness?	○ Yes ○ No
SACRUM - Skin intact/without redness?	○ Yes ○ No
KNEES - Both intact/without redness?	○ Yes ○ No
HEELS - Both intact/without redness?	○ Yes ○ No
MALLEOLUS - Both intact/without redness?	○ Yes ○ No
Details	
	If ANY of the previous 9 questions have a "NO" answer, BRIEFLY describe details, then add and DOCUMENT on Pressure Ulcer Assessment Intervention.

3. GENERAL ASSESSMENT (Shift Assessment Med/Surg)

- **CV ASSESSMENT (bottom of section….)**

SKIN / GENERALIZED ASSESSMENT				
Temperature	○ Warm	○ Hot	○ Cool	○ Cold
Color	○ Normal ○ Ashen ○ Cyanotic ○ Dusky ○ Other	○ Flushed ○ Jaundiced ○ Mottled	○ Pale ○ Ruddy ○ Sallow	
Moisture	○ Dry	○ Diaphoretic	○ Clammy	
Turgor	○ Good	○ Fair	○ Poor	
ADDITIONAL INFORMATION				
CV Comment				

- **SKIN INTEGRITY ASSESSMENT**

Skin is Intact.

NO Ulcers, Wounds, or other Skin Alterations

SKIN INTEGRITY ASSESSMENT	
Skin intact without ulcers,wounds,or other skin alterations	○ Yes ○ No If YES, skin is intact, no further skin documentation required. If NO, Must Document Details On: ***If pressure ulcer present - use Pressure Ulcer Assessment **If wound present - use Wound Assessment *If rash, skin tear,abrasion/bruising, etc present - Document BELOW on Skin Integrity System Assessment.

SKIN - Occurrence #1					
Skin Issue	○ Abrasion ○ Amputation ○ Blister(s) ○ Burn ○ Contusion	○ Dermatitis ○ Dialysis access ○ Ecchymosis ○ Eschar ○ Laceration	○ Linear split ○ Ostomy ○ Petechiae ○ Port ○ Purple area	○ Rash ○ Scab ○ Scar(s) ○ Skin tear(s) ○ Tube(s)	☐ Other
→ Body Location	☐ Generalized ☐ Anterior	☐ Left ☐ Posterior	☐ Right ☐ Medial	☐ Upper ☐ Lateral	☐ Lower
→ Body Site (Listed Head to Toe)	○ BODY ○ Head ○ Scalp ○ Face ○ Nose ○ Neck ○ Cheek ○ Chin ○ Other	○ Eye ○ Ear ○ Shoulder ○ Axilla ○ Arm ○ Elbow ○ Wrist ○ Hand	○ Finger ○ Thumb ○ Nailbed ○ Breast ○ Chest ○ Back ○ Trunk ○ Sacrum	○ Coccyx ○ Buttock ○ Ischium ○ Abdomen ○ Hip/Trochanter ○ Perineum ○ Genitalia ○ Groin	○ Leg ○ Thigh ○ Knee ○ Calf ○ Ankle ○ Foot ○ Toe ○ Heel
SKIN CONDITION					
Skin symptom(s)	☐ Diaphoretic ☐ Dry ☐ Edematous ☐ Excoriated/Denuded ☐ Flaky ☐ IAD-Incon Asso Dermatitis ☐ Intertrigo Dermatitis	☐ Macerated ☐ Moist ☐ Pruritis ☐ Rash ☐ Scaly ☐ Weepy			
Temperature	○ Warm	○ Hot	○ Cool	○ Cold	
Color	○ Normal ○ Cyanotic ○ Dusky ○ Ecchymosis ○ Other	○ Erythema/Redness ○ Flushed ○ Hemosiderin staining ○ Jaundiced	○ Mottled ○ Pale ○ Pink		
Additional information					
REMEMBER: **Pressure Ulcers are documented on Pressure Ulcer Assessment **Wounds are documented on Wound Assessment					

Body Location	• Left • Right • Bilateral	• Upper • Middle • Lower	• Anterior • Posterior	• Medial • Lateral	• Proximal • Distal	• Dorsal • Volar

4. SKIN RISK ASSESSMENT scale

SKIN RISK ASSESSMENT SCALE	
Moisture Risk	○ Constantly Moist ○ Very Moist ○ Occasionally Moist ○ Rarely Moist
Sensory Perception	○ Completely Limited ○ Very Limited ○ Slightly Limited ○ No Impairment
Activity Risk	○ Bedfast ○ Chairfast ○ Walks Occasionally ○ Walks Frequently
Mobility Risk	○ Completely Immobile ○ Very Limited ○ Slightly Limited ○ No Limitations
Nutrition	○ Very Poor ○ Probably Inadequate ○ Adequate ○ Excellent
Friction & Shear Risk	○ Problem ○ Potential Problem ○ No Apparent Problem
Skin Risk Total Score	☐ (points) Patients with a total score of 18 or less are considered to be at risk of developing pressure ulcers: - 15 to 18 = Mild Risk - 13 to 14 = Moderate Risk - 10 to 12 = High Risk - 9 or less = Very High Risk ****If score is 18 or less, ADD "Turn and position patient every 2 hours" and "Skin Care Products" interventions!

MEASURES BASED ON SCORE OF 18 OR LESS	
Potential for skin breakdown	○ YES, Risk Score is 6-18 ○ NO, Risk Score is 19-23
Sensory perception, mobility & activity measures	☐ Turn ~~and position Q2H~~ Routinely ☐ Heel protectors ☐ Keep HOB < 30 degrees ☐ Suspend heels off bed ☐ Chair cushion/pillow ☐ Air overlay mattress ☐ Press. redistribution bed ☐ Low air-loss bed ☐ Involve PT if necessary ☐ Air tap repositioner ☐ N/A **Low Air Loss bed - look for ~~PINK label on foot of bed~~ scale
Moisture management	☐ Moisture barrier ☐ Fecal Management ☐ Peri-cleanser ☐ Indwelling catheter ☐ Check skin folds ☐ Separate skin folds ☐ Alter. incontinence meas. ☐ Female urine mgmt system ☐ N/A
Nutrition measures	☐ Nutrition consult ordered ☐ NPO status ☐ Encourage p.o. intake ☐ IV Fluids ☐ Feeding tube ☐ Supplements ☐ N/A
Friction & shear measures	☐ HOB @ lowest position ☐ Remove stockings Q shift ☐ Moisturize heels & skin ☐ Have pt. use a trapeze ☐ Inspect under devices ☐ Use LIFT sheets ☐ N/A ☐ Foam dressing
SKIN STAGE AND TREATMENT GUIDELINES	
Skin Stage and Treatment Guidelines	☐ NOTE: Contact WOCN or CNS/Director if a specialty mattress or bed is needed. NOTE: Suspected deep tissue injury,Stage I,II,III,IV,or Unstageable requires documentation on PRESSURE ULCER ASSESSMENT! NOTE: Refer to the Skin Care Guidelines for appropriate treatment in the absence of MD order.

Text Foam Dressing ☐

Nursing Standards of Practice

*All policies and procedures are reviewed and/or revised at least every two years.
A hard copy of all policies and procedures, along with attachments, is maintained in Nursing Administration office.

**Last reviewed/revised: 6/19

Click here to return to I

S *Seclusion (Also in AP+P
PCS.1633 manual)
*Sedation Scale

Skin Care Management

* *Skin Care Standard*
* ~~*Skin Integrity Protocol*~~
* *Perineal Skin Integrity Guidelines*
* *Pressure Ulcer-Prevention, Assessment, Management*
* *Pressure Ulcer (Injury) Staging Guidelines*
* *Skin Tears Guidelines*

Northwell Health

System Patient Care Services

POLICY TITLE: **Pressure Ulcer: Prevention, Assessment, and Management**	**System Nursing Policy and I**
POLICY #:	**CATEGORY SECTION: Syst Services Policy, Procedure &**
System Approval Date: 1/28/2016 3/2021	**Effective Date: 12/2001**

Skin Care Policies/Protocols 2021

Current Phelps Hospital Policy/Standard	Suggestions....	What do you think?
1. ~~Ostomy and Wound Consultation Services~~	?	
2. Rectal Tube Insertion and Use (not Dignicare)	*Can 2 these be combined*	
3. Dignicare Rectal Tube	*above*	Fecal Management System?
4. **Negative Pressure Wound Therapy (NPWT)**	Update	
5. **Skin Care Standard** Management Policy 7/2015	?	
Northwell Guidelines:		
6. NW: Pressure Injury Prevention, Assessment & Management	Keep	PCS.1666 2/21
7. NW: Perineal Skin Integrity Guidelines	Keep	
8. NW: Pressure Ulcer (Injury) Staging Guidelines	Keep	
9. NW: Skin Tears Guidelines	Keep	
10. NW: Biliary Drain (NEW)	NEW/Educate	PCS.
11. NW: Oral Hygiene Care for Dependent Patients	New/Educate	PCS.1621 2/21
12. NW: Skin Tool Kit		
Current Protocols		
1. ~~Diaper Use~~	Retire	
2. ~~External Catheter Management~~	Retire	
3. Fecal Management System	Combine/Retire (above)	
4. ~~Incontinent Patient~~	Retire	
5. ~~Negative Pressure Wound Therapy (NPWT)~~	Retire	
6. Ostomy Management	Convert to a Policy	
7. ~~Skin Integrity~~	Retire	
8. ~~VAC Protocol~~	Retire	
9. Stomatitis (Oral) Mucositis	Update with NW policy	10/15
10. ~~Pull-Ups~~	Retire	