Blue Ridge HealthCare System
Interdisciplinary
Patient Care
Specialty Services

Assessment for Skin Integrity

Origination Date: 10/2012

Review/Revised Date: 10/28/2015

APPLICABILITY:

Carolinas HealthCare System Blue Ridge

POLICY:

The nursing staff will implement the Pressure Ulcer Prevention and Treatment Protocol based upon their assessment of the skin on admission and every shift. The nursing staff will develop a plan of care based upon these prevention and treatment guidelines and alter the plan of care based upon changes in the patient status. The nursing staff will document the education and assessment plan in the patient's electronic medical record.

PURPOSE:

A head to toe skin assessment will be performed on admission and every shift. The risk assessment tool will be used to determine the need for prevention practices.

PROCESS:

A. Perform a head to toe assessment upon admission and every shift.
B. Determine the Braden Scale for predicting pressure ulcer risk assessment on admission and at least daily.
    a. Patients with a Braden Score of 18 or less are at a higher risk for developing a pressure ulcer and other skin breakdown. Prevention measures will be implemented using CHS Blue Ridge Pressure Ulcer and Prevention Protocol.
    b. Treatment parameters will be initiated upon assessment of a pressure ulcer. The nurse will determine the stage of the pressure ulcer and use the interventions outlined in the CHS Blue Ridge Pressure Ulcer Prevention and Treatment Protocol.

C. Determine the plan of care based upon the CHS Blue Ridge Pressure Ulcer Prevention and Treatment Protocol and document in the medical record the plan and the interventions.
D. Educate the patient and or family of any interventions or preventative measures used as outlined in the CHS Blue Ridge Pressure Ulcer Prevention and Treatment Protocol.
E. Notify the physician or appropriate care provider of any notable changes in condition.

DOCUMENTATION:

A. Document prevention strategies used every shift and as performed.
B. Document treatment interventions as performed.
C. Document any patient or family education related to skin integrity.
D. Document any notable changes in patient condition related to skin integrity issues and re-evaluate risk assessment based upon changes.

REFERENCES:

Ayello, E and Sibbald, G. Nursing Standard of Practice Protocol: Pressure Ulcer Prevention and Skin Tear Prevention. Evidenced Based Content available at http://consultgerirn.org. Updated July 2012.

Bolton, L. Which Pressure Ulcer Risk Assessment Scales are Valid for Use in the Clinical Setting? (2007) Journal of Wound, Ostomy and Continence Nursing.

Institute of HealthCare Improvement. Prevention of Pressure Ulcers, Ihi.org 2012.

National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: clinical practice guideline. Washington, D.C.: National Pressure Ulcer Advisory Panel; 2009.

WOCN Position Statement on Pressure Ulcer Staging (2011) available at wocn.org last accessed October 16, 2012.

WOCN Position Statement on Avoidable versus Unavoidable Pressure Ulcers (2009) available at wocn.org last accessed October 16, 2012.