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| SUBJECT: SKIN CARE PROTOCOL | NO.  |
| 1. Nurse aides and Certified nurse aides are to notify the nurse of any changes of the skin while performing daily cares. This includes completing a bath/shower assessment on all residents when bathing or showering them. The nurse is then to notify the Director of Nursing.
2. The nurse will start a newly acquired skin care sheet. The sheet is turned into the DON for assessment and staging of the area.
3. The nurse will then notify the MD and obtain orders for appropriate treatment.
4. The nurse will notify the dietary manager of any Stage II or greater. Dietary to make appropriate recommendations to the MD.
5. The Director of Nursing or her designated appointee according to current staging guidelines will stage pressure ulcers.
6. Wounds will be assessed with each dressing change and at a minimum weekly. They will be measured and charted on accordingly.
7. Pain will be assessed with dressing changes and prn and charted using the pain scale of 1 – 10 in the cognitively intact. Nonverbal cues will be assessed in the cognitively impaired.
8. Weekly documentation to include ulcer location, stage, size, exudates amount, pain, wound bed characteristics and description of ulcer margins, surrounding skin, and odor noted.
9. If no progress is noted within 2-4 week time frame, the nurse will reassess the pressure ulcer for change in treatment.
10. Incontinence should be managed in the following ways.
11. Establish a bowel and bladder program if appropriate.
12. Cleanse skin gently at each time of soiling with soap and water.
13. Use incontinence skin barriers per Winning Wheels formulary.
14. Select under pads, diapers, or briefs that are absorbent and wick moisture away from the skin.
15. Consider use of pouching system or collection device to contain urine or stool.
16. Consider appropriateness of short term indwelling catheter to prevent contamination of pressure ulcer.
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| SUBJECT: SKIN CARE PROTOCOL | NO.  |
| 1. Treatment will be based on stage of pressure ulcer and Winning Wheel’s wound formulary.
2. Use proper positioning, turning, and transferring techniques to minimize skin injury due to friction and shear forces.
3. Educate residents who are cognitively able to reposition self frequently throughout the day.
4. Assess pressure ulcer and surrounding skin for any signs of infection and notify MD.
5. Weekly skin checks to be done by licensed nurse and documented on the appropriate forms.
6. Initiate a rehabilitation program to maintain or improve mobility/activity status, if appropriate.

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