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| SUBJECT: SKIN CARE PROTOCOL | NO.  |
| 1. Certified nursing assistants are to notify the nurse of any changes of the skin while performing daily cares. This includes completing a Skin Attention Form on all residents when bathing or showering them. The C.N.A. Skin Attention Form is for QA purposes only and will be kept for 90 days by the Wound Care Coordinator and then destroyed.
2. The nurse will complete a RiskWatch report for new skin areas. The report will be reviewed by the DON or her designee during A.M. meeting with the IDT team and forwarded to the Wound Care Coordinator.
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.
5. The Wound Care Coordinator will stage pressure ulcers according to current staging guidelines.
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 a numbered pain scale for the resident who is cognitively intact. Nonverbal cues will be assessed in the cognitively impaired.
8. Weekly documentation to include ulcer location, stage, size, on set date, place acquired, appearance, status, current treatment and dietary interventions.
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 pre-moistened towelettes or soap and water.
13. Use incontinence skin barriers per Winning Wheels formulary.
14. Select under pads 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.
17. Treatment will be based on stage of pressure ulcer, Winning Wheel’s current wound formulary and physician orders.
18. Use proper positioning, turning, and transferring techniques to minimize skin injury due to friction and shear forces.
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| SUBJECT: SKIN CARE PROTOCOL | NO.  |
| 1. Educate residents who are cognitively intact and able to reposition self frequently throughout the day.
2. Assess pressure ulcer and surrounding skin for any signs of infection and notify MD.
3. Weekly skin checks to be done by licensed nurse and documented on the appropriate forms.
4. If appropriate, initiate a rehabilitation program to maintain or improve mobility/activity status.

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