Transforming Lives

2022 Region Presentation Training
Skin Observation Protocol (SOP)
Nurse Delegation

DSHS ALTSA-Home & Community Services – Nursing Services & Adult Day Services, Program Manager

Susan Worthington, BSN, RN

Washington State Department of Social & Health Services

Transforming lives

Client Experience and Care should always be the main focus

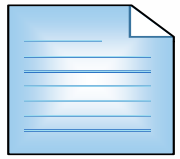
This Diagram represents the journey of a patient from admission to discharge

HOSPITAL

DSHS (HCS) REGION

AAA

Patient is admitted to hospital with HX of Diabetes, CHF and falls X10



Hospital Personnel completes DSHS 10-570 Form

Hospital: Faxes DSHS 10-570 form to DSHS Region Office

DSHS-CM completes CARE Assessment for functional and financial eligibility. Communicates CARE hours determination and applicable services.

Does client want Services in the HOME?

NO

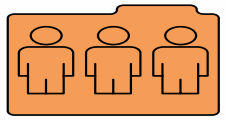
Client stays in hospital for 4-6 months until placement is found in AFH or ALF

HCS Intake receives Fax and inputs request into Intake DB

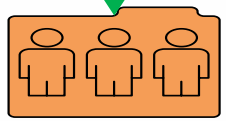
Case Manager reviews file and schedules appointment with client

Yes, Client is Discharged to Home

Client is placed in AFH or ALF



Case is transferred to Residential CM



Client is transferred in BARCODE to Area Agency on Aging (AAA)

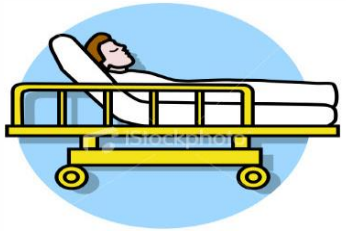
AAA CM meets client & Caregiver in HOME

6 months later in the life of our client

Hospital

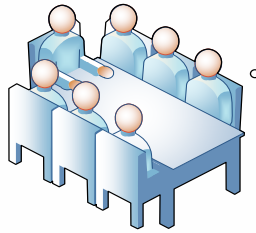
DSHS (HCS) Region

Area Agency on Aging (AAA)



How will the hospital determine clients Medicaid Eligibility?

How is CM notified of client hospitalization.



Is the CM a part of Discharge Planning discussion?

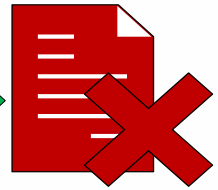
How and Who will introduce Nursing Service options to client?

Client at home with caregiver

6 months later, sent to the hospital

Client discharged back Home. Family alerts CM Of hospital visit

AAA CM performs a "Significant Change"



Client declines, needs being met by caregiver. No referral Sent.

Long Term Care Manual

- **Chapter 24 – Nursing Services**
  - Nursing Services
  - SOP

- **Management Bulletins – SOP**
  - H15-010 - SOP - 2/03/2015
  - H15-066 – SOP - 9/21/2015
  - H18-022 - SOP - 4/26/2018

Chapter 24 – Nursing Services

Chapter 24 - Nursing Services

The purpose of this section is to describe the process for identifying and referring clients who may benefit from Nursing Services. This section also outlines what Nursing Services staff are responsible for: responding to referrals, performing nursing service activities (e.g. file review), and documenting their recommendations and activities.

Section Summary

- What are Nursing Services?
- Identifying and Referring Clients for Nursing Services - Who should you refer for nursing services?
- Responding to Referrals - Read about how soon nursing services staff should respond to referrals.
- Performing Nursing Services Activities - Find out what types of activities **are** part of nursing services (e.g. file reviews and consultation) and what activities **are not** part of nursing services.
- Nursing Services Reporting Requirements - AAA, HCS, and contracted nursing services resources are required to provide monthly reports to the Nursing Services Program Manager. Learn about what needs to be included in these reports.

Requirements of the Case Manager

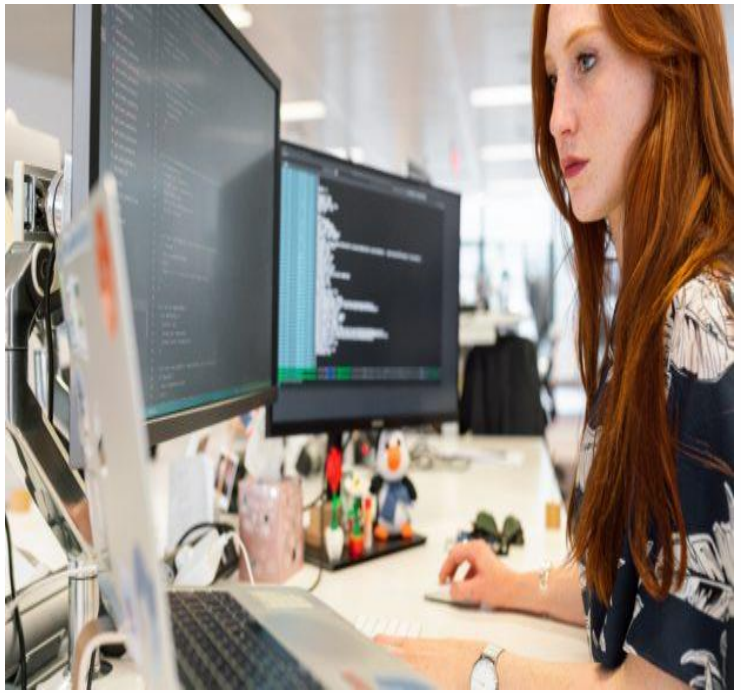
1. Administers the CARE Assessment
2. Identifies when the Skin Observation Protocol is triggered
3. Makes referrals to Nursing Services as needed
4. Provides Skin Observation Protocol required activities
5. Documents in CARE
6. Ensures the Skin Observation Protocol is completed

CASE MANAGER RESPONSIBILITIES

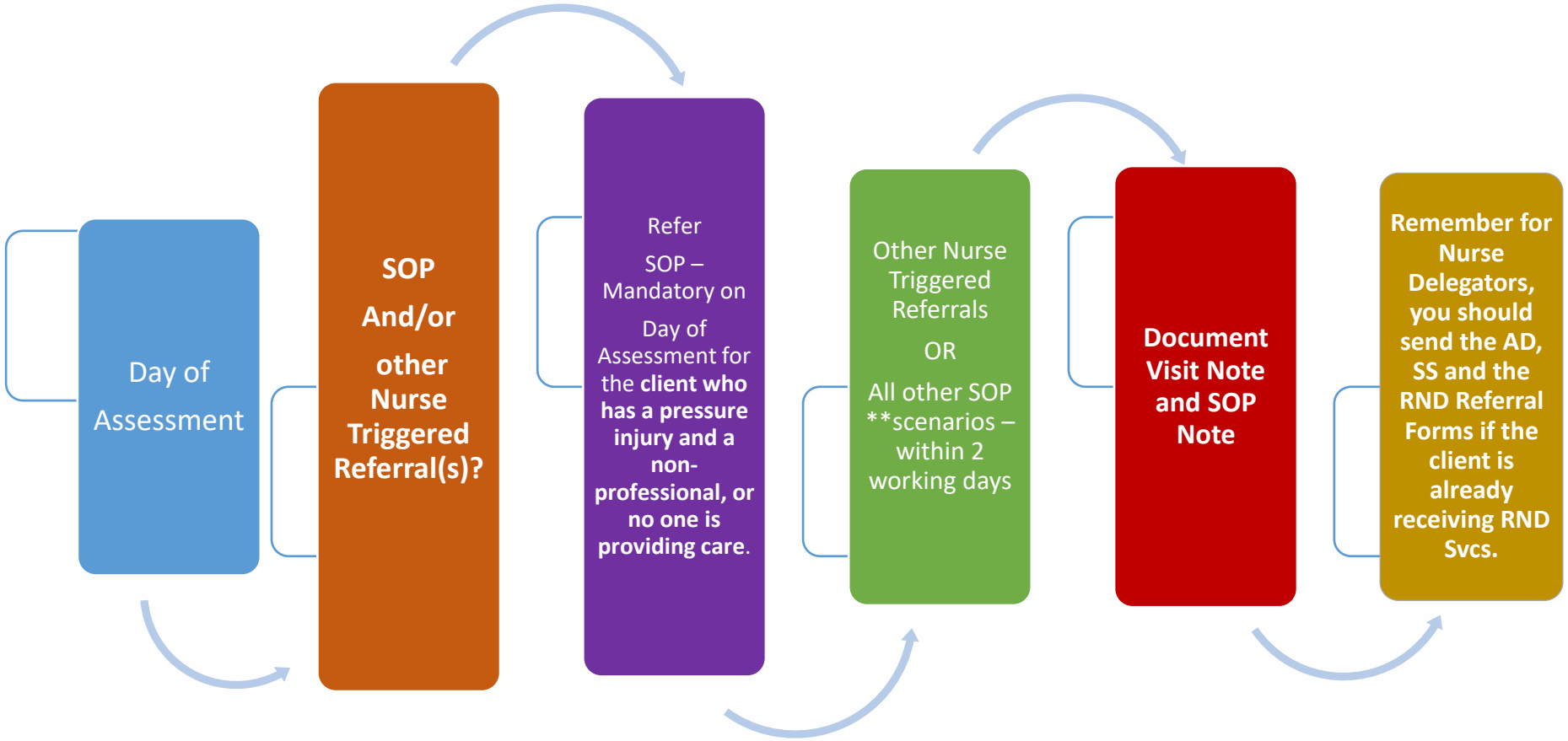
- **Identify in CARE**
  - **SOP triggered**
  - **Send referral for SOP and include all the other triggered referrals**
  - **Document in CARE referral process**
  - **Send Referral to RND if appropriate**
- **Consideration**
  - **Does the client have a Pressure Injury?**
  - **Is there a caregiver treating the pressure injury?**
  - **Is the caregiver a professional or non-professional?**

CASE MANAGERS RESPONSIBILITIES

- **Case Manager determines appropriate provider**
  - **Nurse Delegator–*clients who receiving delegation already***
  - **AAA**
  - **Nursing agency**



Case Manager – Day of Assessment



Identifying and referring clients to nursing services

What are Nursing Services?

- **Health related assessment & *consultation* program**
  - Developing and implementing a plan of care (Service Summary)

Who is eligible for Nursing Services?

MPC and COPES clients who meet any of the referral criteria should be considered for Nursing Services. NOTE: Other resources may be available for AAA non-core clients. The referral criteria is the minimum set of criteria, as shown in the Nursing Referral Indicators screen of CARE, should be used when considering a client for nursing services.

RCW 74..09.520 (2)(B)&(C)

The department shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review.

WAC Reference:

- MPC
  - 388-106-0200(3)
- COPES
  - 388-106-0300(9)
- Residential – **Live In**
  - 388-106-0305(5)

What are the goals of Nursing Services ?

- **Maximum level of Quality of Life**
- **Support person centered planning**
- **Bring medical expertise to client at place of residence**
- **Decrease cost**

Who Provides Nursing Services

- HCS Nurse Care Consultants (NCC)
- HCS Community Nurse Consultants (CNC)
- AAA Nurses
- Contracted nurses
- Home Health agencies
- *RN Delegators – clients will be receiving delegation already

What is the referral criteria?

- **Nursing Referral Indicators**
  - Unstable or Potentially unstable diagnosis
  - Medication Regimen affecting plan
  - Nutrition status affecting plan
  - Immobility status affecting plan
  - Skin Breakdown or History
  - Skin Observation Protocol

Triggered Nurse Referrals

What services does a client receive?

- **Nursing services from a registered nurse based on CARE Assessment**
  - **File Review**
  - **Nursing Assessment/Reassessment**
  - **Instructions/education to client and provider**
  - **Healthcare & Resource Coordination**
  - **Evaluation of health-related needs affecting service plan and delivery**

Who is the Caregiver?

Non-Professional

- Individual Provider
- Agency Home Care worker
- Residential Caregiver Family Member
- Informal Caregivers/support

Professional (HCP)

- Physician
- Wound care clinic
- ARNP, PA-C, RN or LPN
- Home Health Nurse
- Physical Therapist

Case Manager & Nurse action Steps
Triggered referrals

What are the Skin Observation Protocol Requirements?

- **HCS-Policy(LTC Chapter 24)**

The Skin Observation Protocol is a **mandatory** protocol that must be completed for each client triggering a highest risk indicator. The protocol must be responded to, and all protocol activities provided, according to the client's skin integrity and caregiver status.

The protocol directs the case manager and/or nurse to:

- Determine whether an observation visit is required or not by a nursing resource;
- What activities must be completed by the case manager and/or the nurse; and
- The documentation requirements for case management and nursing staff.

If the skin protocol is triggered, you will need to follow certain steps when:

- Skin observation is not required;
- Skin observation is required;
- Skin observation is delayed.

Skin Observation Protocol

Multiple Skin Tones

SKIN OBSERVATION PROTOCOL (SOP)

Skin Observation Protocol (SOP)

The Skin Observation Protocol is based on ***three factors:***

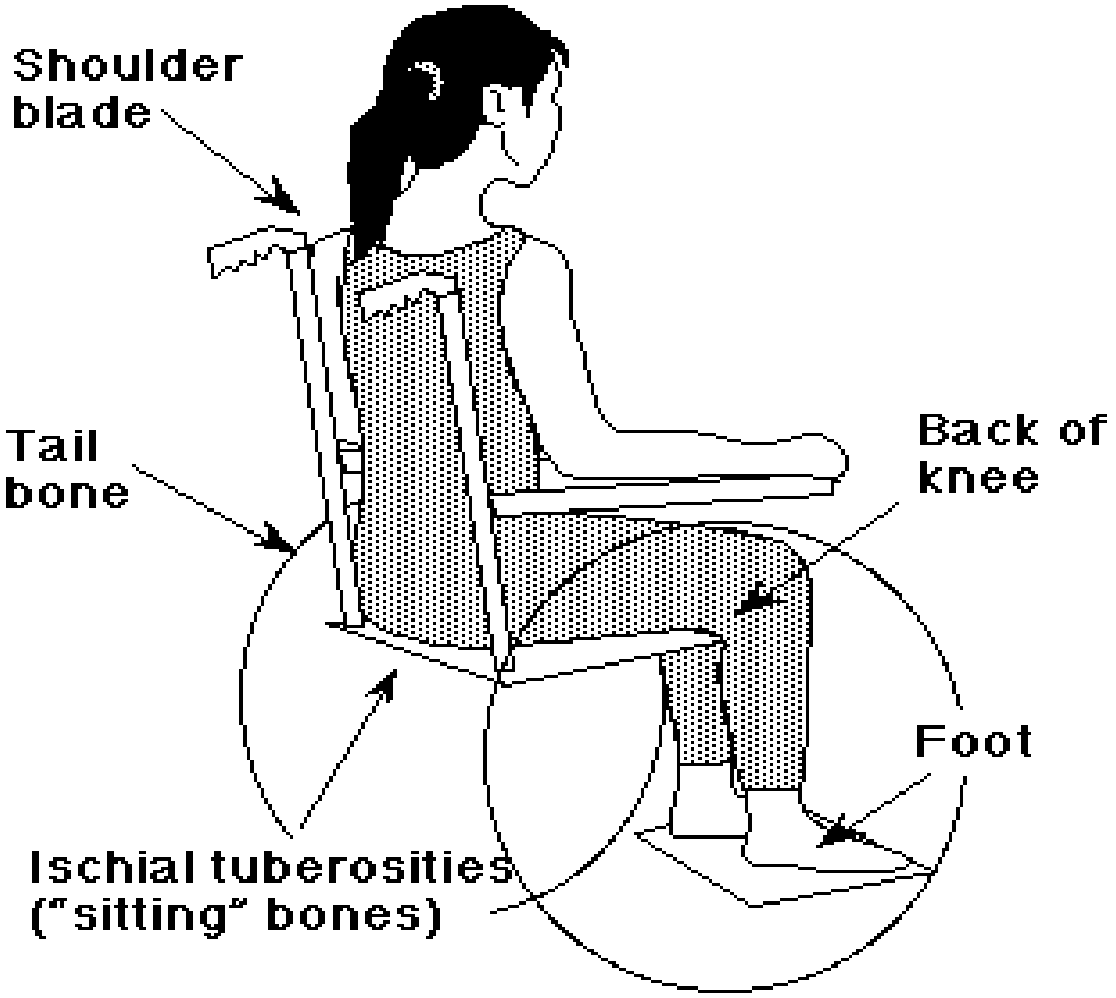
1. Whether the client has a known pressure Injury; and
2. Whether there is a caregiver involved; and what type of caregiver; and
3. Whether there is adequate skin care treatment in place.

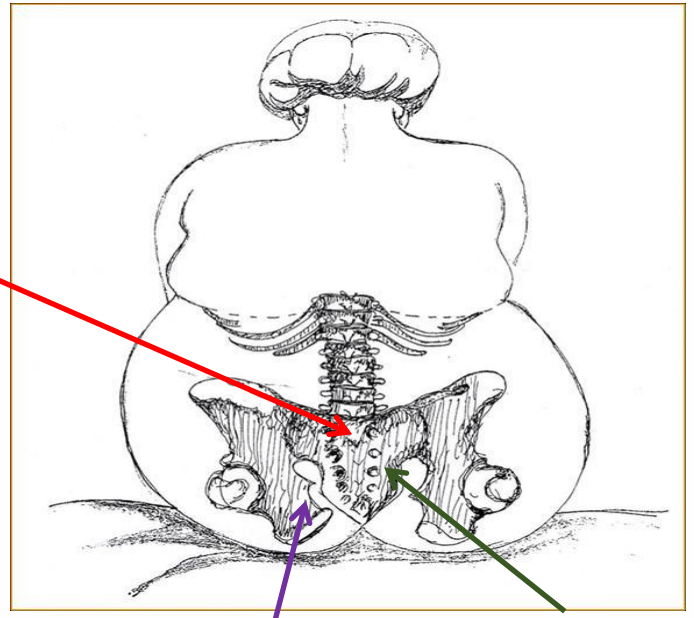
What is a Pressure Injury?

- **"A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer/injury and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue."**

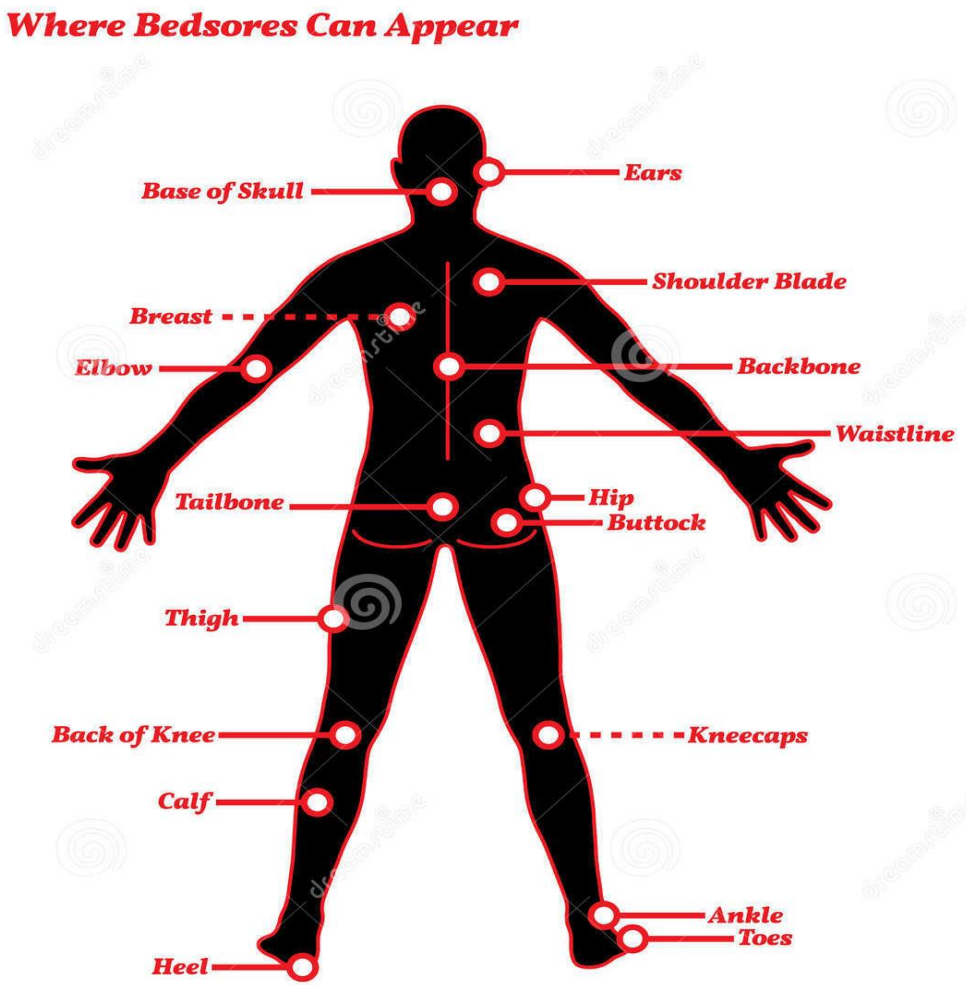
- ***National Pressure Injury Advisory Panel and European Pressure Injury Advisory Panel. (2016). Prevention and treatment of pressure Injuries: clinical practice guideline. Washington DC: National Pressure Injury Advisory Panel.***

Bony Prominence Locations

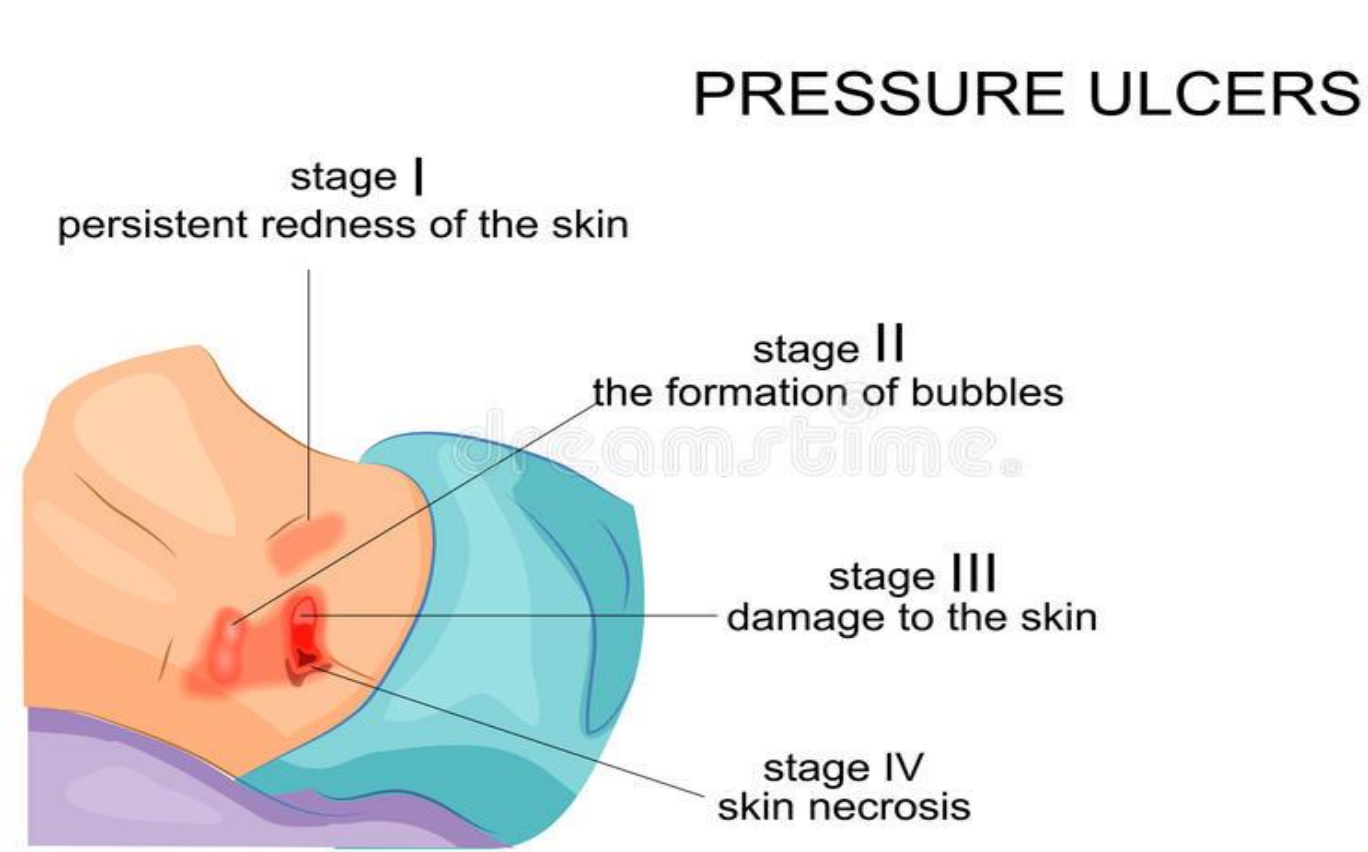




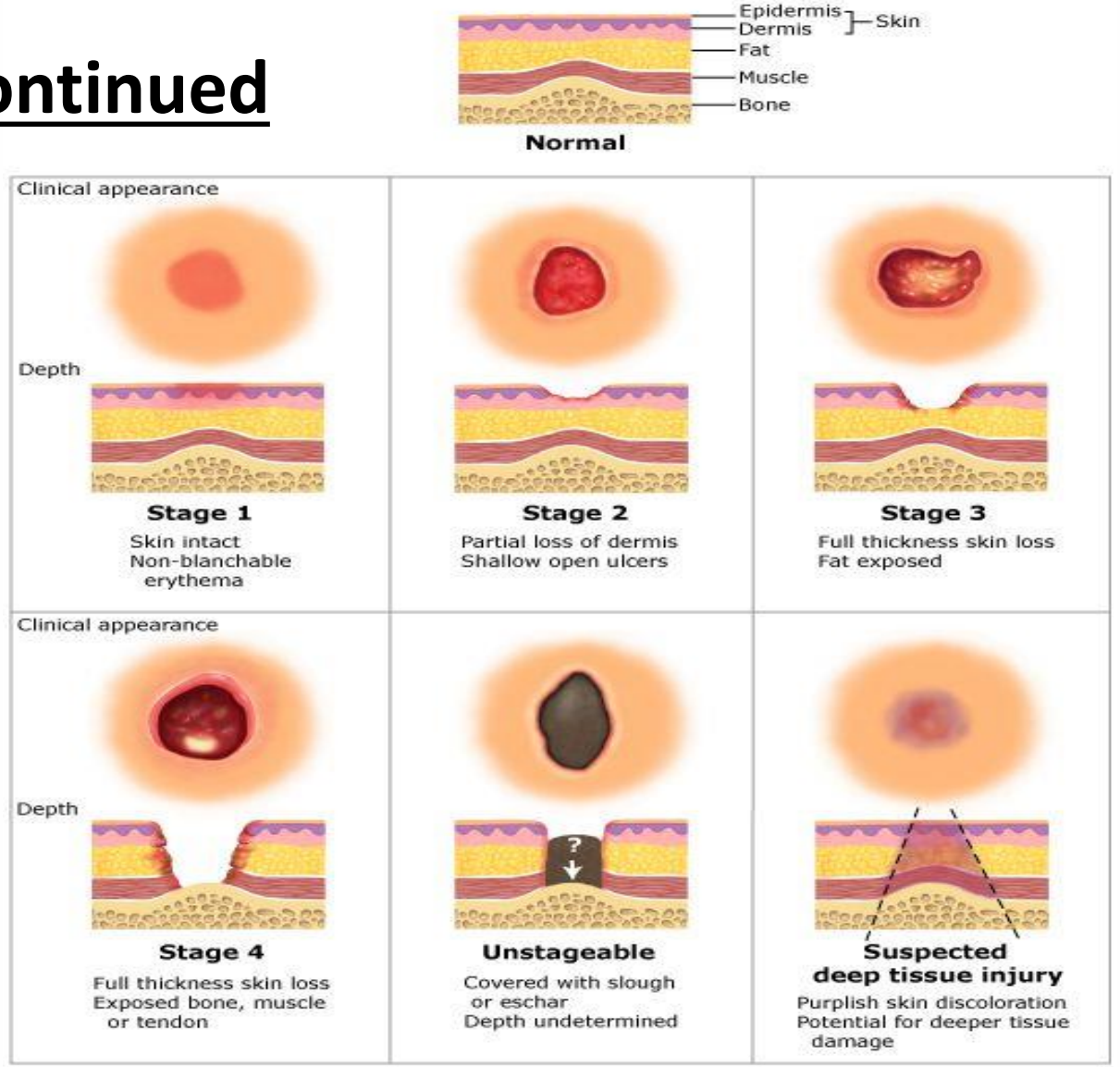
MANY AREAS FOR PRESSURE INJURIES: *BE AWARE!*



Pressure Injuries Continued



Pressure Injuries Continued



HOW TO CLASSIFY AND DOCUMENT PRESSURE INJURIES

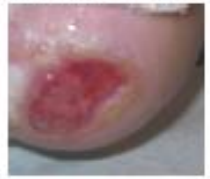
The NPUAP/EPUAP Pressure injury classification system provides a consistent and accurate means by which the severity of a pressure injury can be communicated and documented.

Stage I pressure injury: non-blanchable erythema

- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate "at risk" persons (a herakling sign of risk).

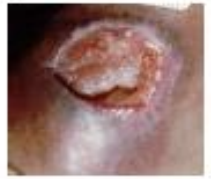
Stage II pressure injury: partial thickness skin loss

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury).
- Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



Stage III pressure injury: full thickness skin loss

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.

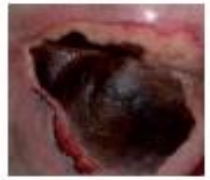


Stage IV pressure injury: full thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

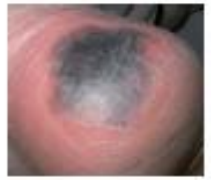
Unstageable pressure injury: depth unknown

- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.



Suspected deep tissue injury: depth unknown

- Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



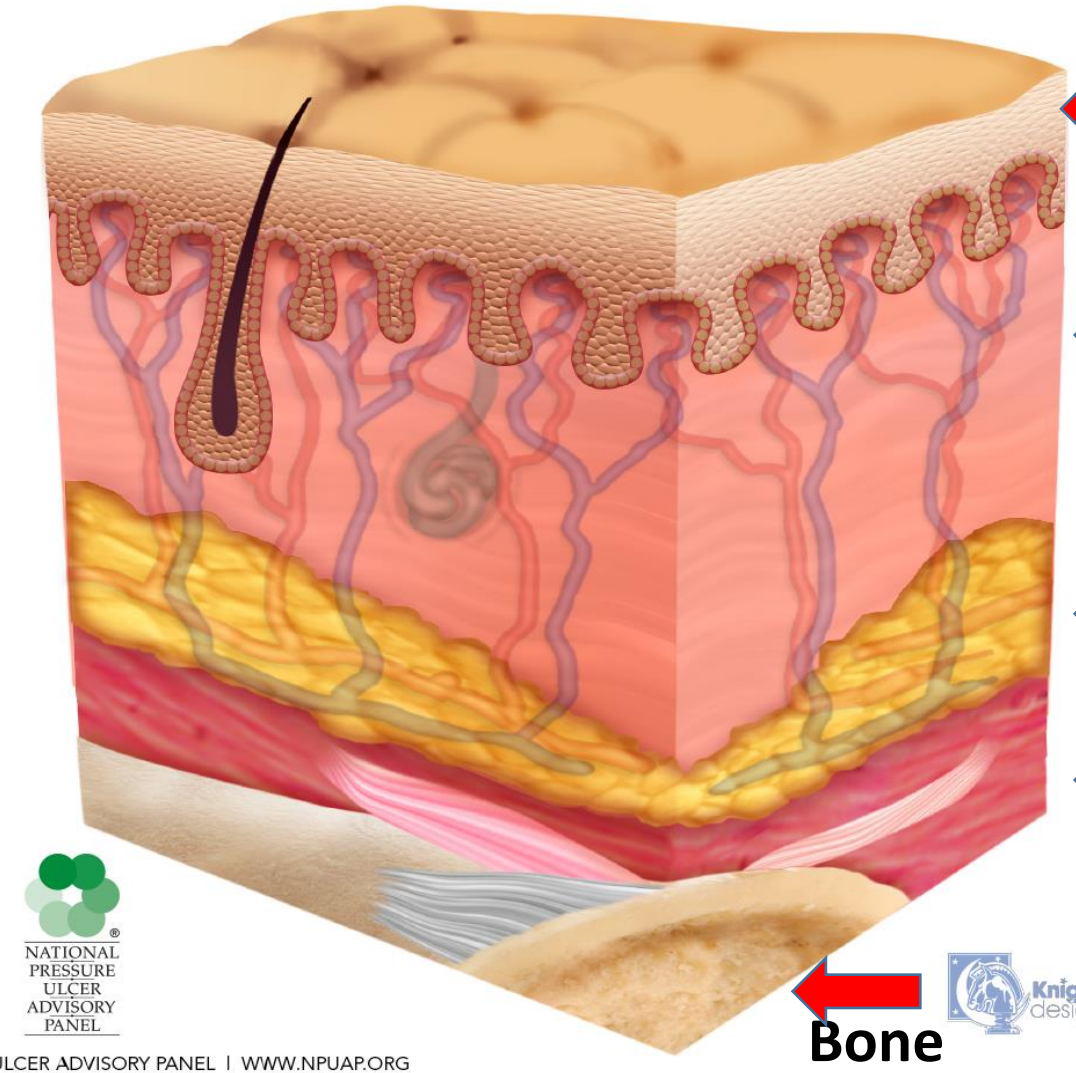
All 3D graphics designed by Jarrad Gittos, Gear Interactive, http://www.gearinteractive.com.au
Photos stage, I/V, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital.
Photos stage II and III courtesy IC Carville, Silver Chain. Used with permission.

MINISTRY OF HEALTH MANATŪ HAUORA

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

NEW ZEALAND WOUND CARE SOCIETY

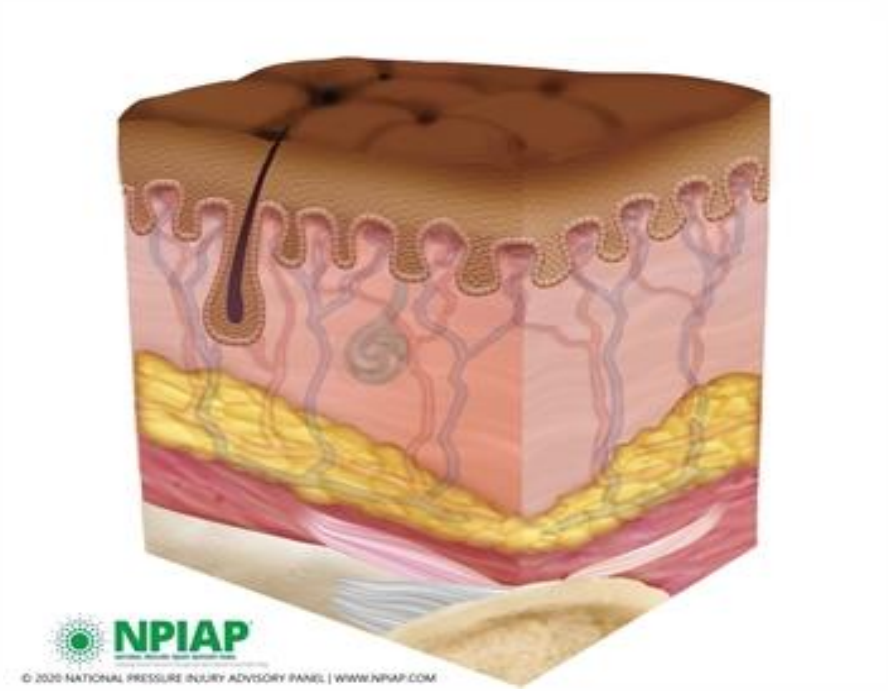
Healthy Skin – Lightly Pigmented



NATIONAL PRESSURE ULCER ADVISORY PANEL

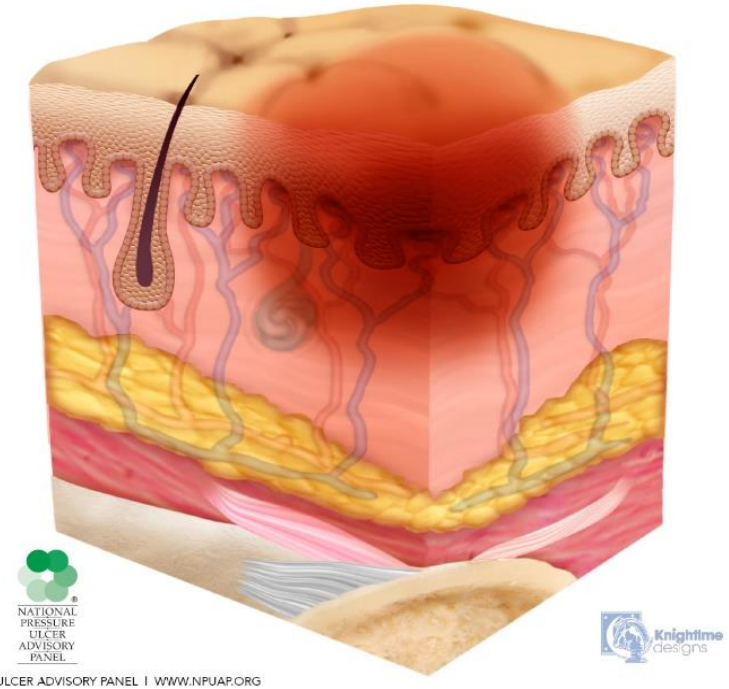
Heathy Skin, Darkly Pigmented

Healthy Skin, Darkly Pigmented

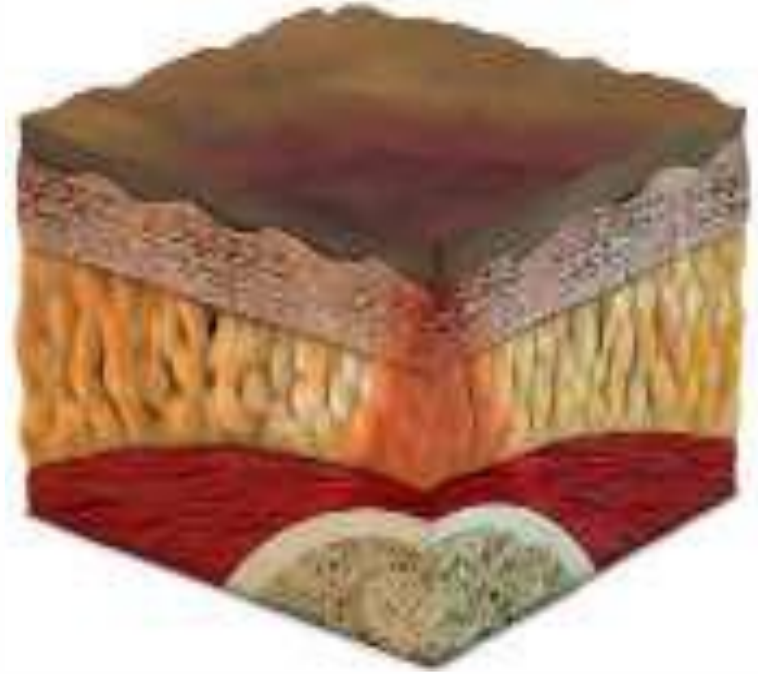


Staging Pressure Injuries- STAGE 1

Stage 1 Pressure Injury – Lightly Pigmented



- Stage 1 Pressure Injury – Dark Skin Tones



Intact skin with non-blanchable redness of a localized area usually over a bony prominence. • Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. • The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. • May be difficult to detect in individuals with dark skin tones. • May indicate “at risk” persons

Stage 1 pressure injuries are characterized by superficial reddening of the skin (or red, blue or purple hues in darkly pigmented skin) that **when pressed does not turn white** (non-blanchable erythema). If the cause of the injury is not relieved, these will progress and form proper ulcers.

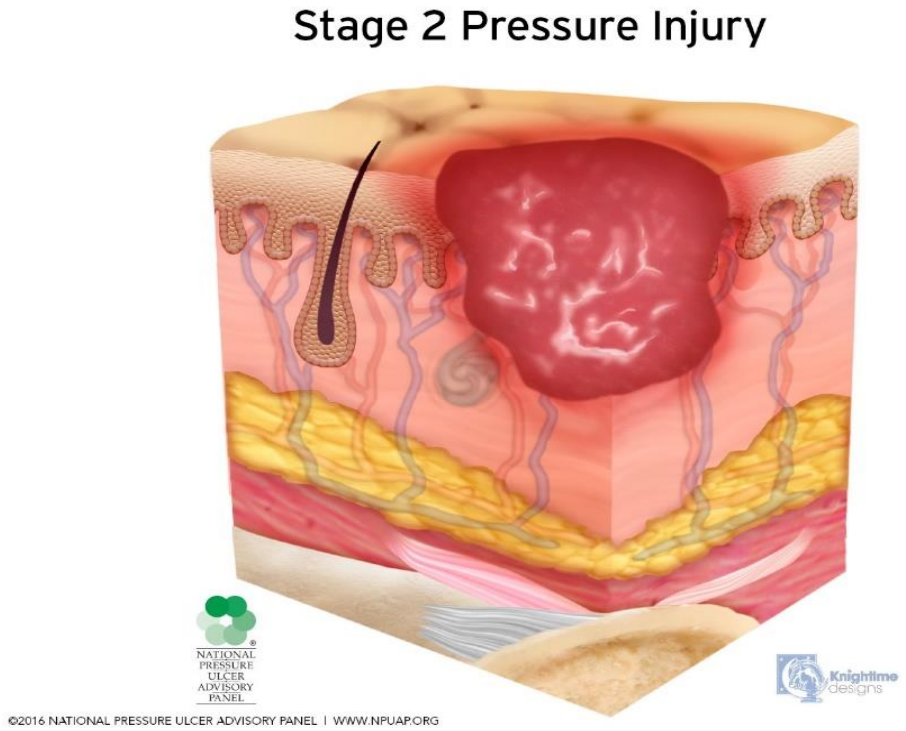
Blanchable vs Non-Blanchable Pressure Injuries

Blanching is usually the primary **indicator of an impending ulcer formation**. Erythema represents redness on the skin that can be blanched. It can be seen in a variety of inflammatory skin disorders. Blood vessels on the skin, such as vascular lesions like spider veins, are blanchable.

Blanchable or non-blanchable erythema that tends to be pink, red or bright red. Non-blanchable erythema **means the skin does not turn white when touched with a finger**.

The analysis showed that people with **non-blanchable erythema** had 2.72 times the odds of developing a new pressure ulcer of Stage 2 or above within 28 days, compared with those without non-blanchable erythema.

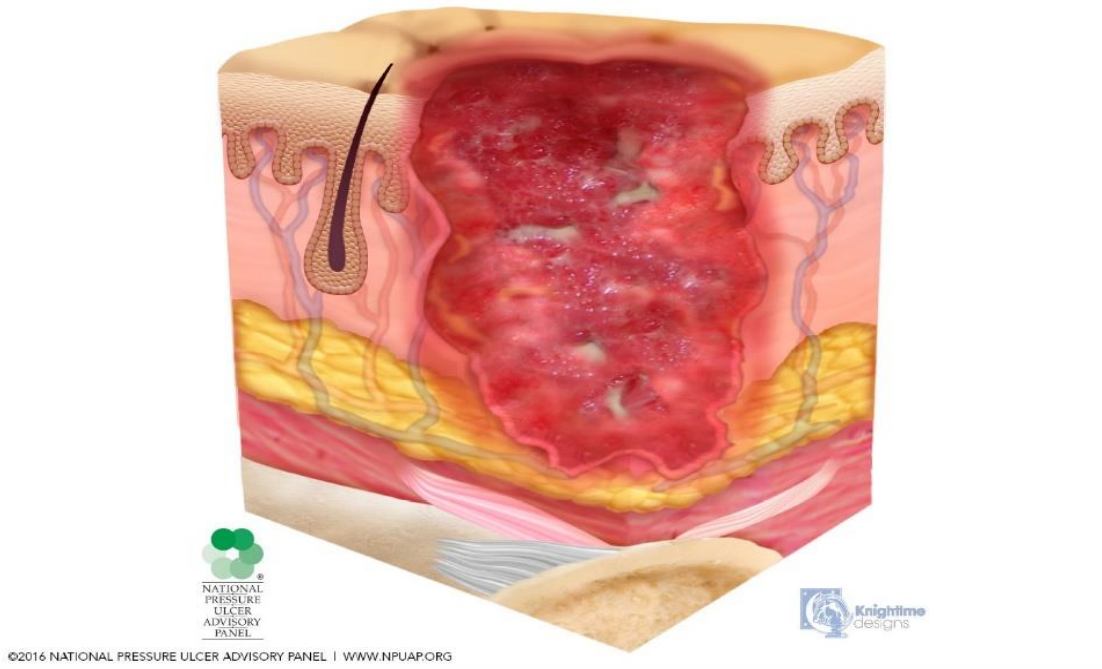
Staging Pressure Injuries- STAGE 2



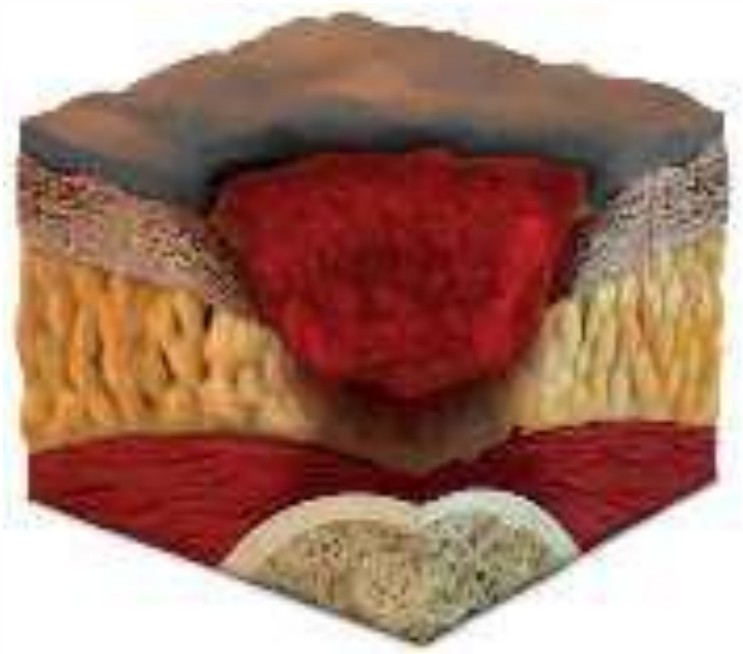
Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough. • May also present as an intact or open/ruptured serum filled blister. • Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury). • Stage II Should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Staging Pressure Injuries- STAGE 3

Stage 3 Pressure Injury



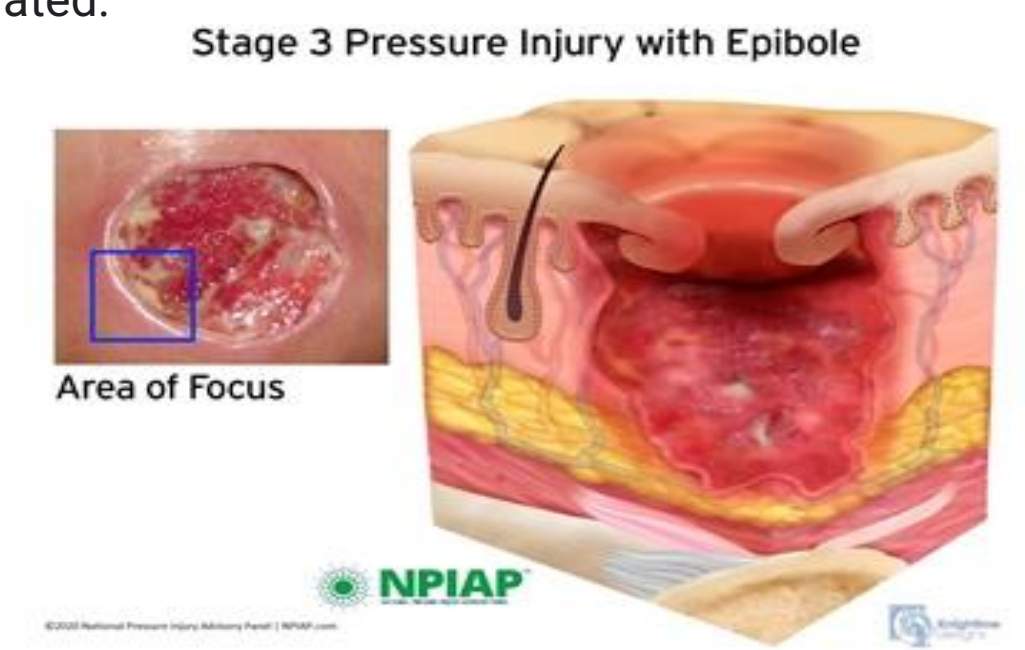
Stage 3 Pressure Injury - Dark Skin Tones



Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. • The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.

Stage 3 with Epibole

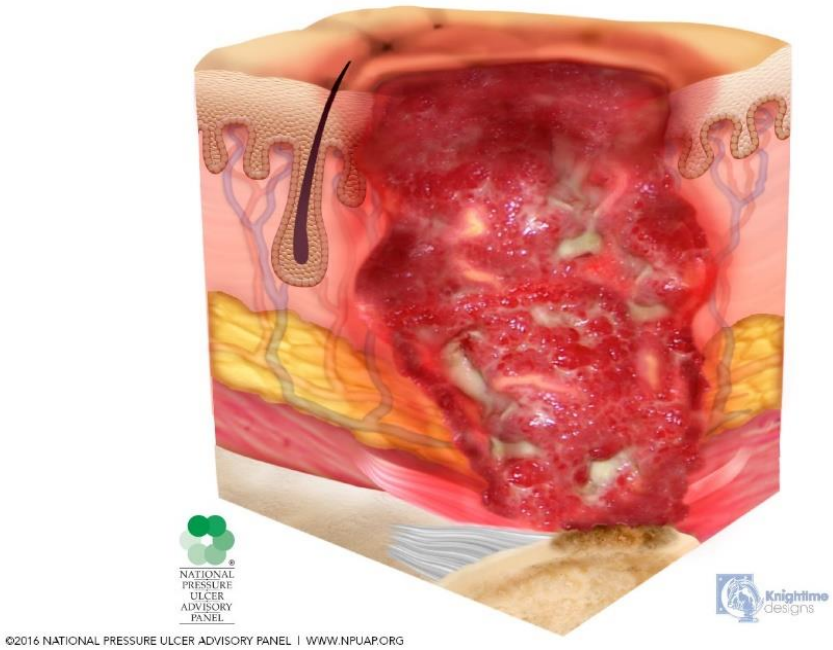
Epibole refers to **rolled or curled-under closed wound edges that may be dry, callused**, or hyperkeratotic. Epibole tends to be lighter in color than surrounding tissue, have a raised and rounded appearance, and may feel hard, rigid, and indurated.



There are many possible reasons why the epidermal margin fails to migrate, including:
•hypoxia (deficiency of oxygen reaching the tissues)
•infection
•desiccation (extreme drying out)
•dressing trauma
•an over-packed wound bed
•an unhealthy wound bed
•the inability to produce the basement membrane for the epithelial cells to adhere to
•cellular senescence (the inability of cells to divide/proliferate)

Staging Pressure Injuries – Stage 4

Stage 4 Pressure Injury

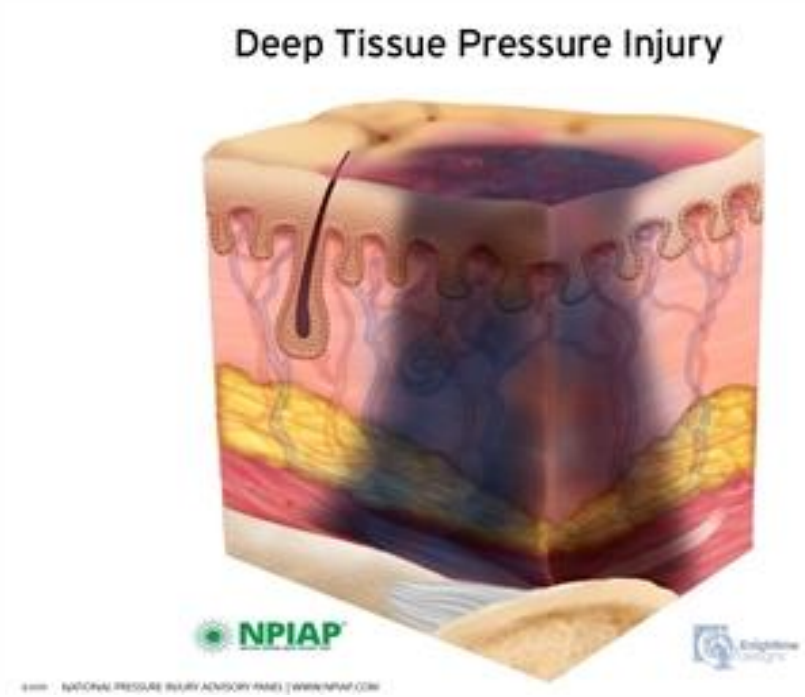


Stage 4 Pressure Injury - Dark Skin Tones

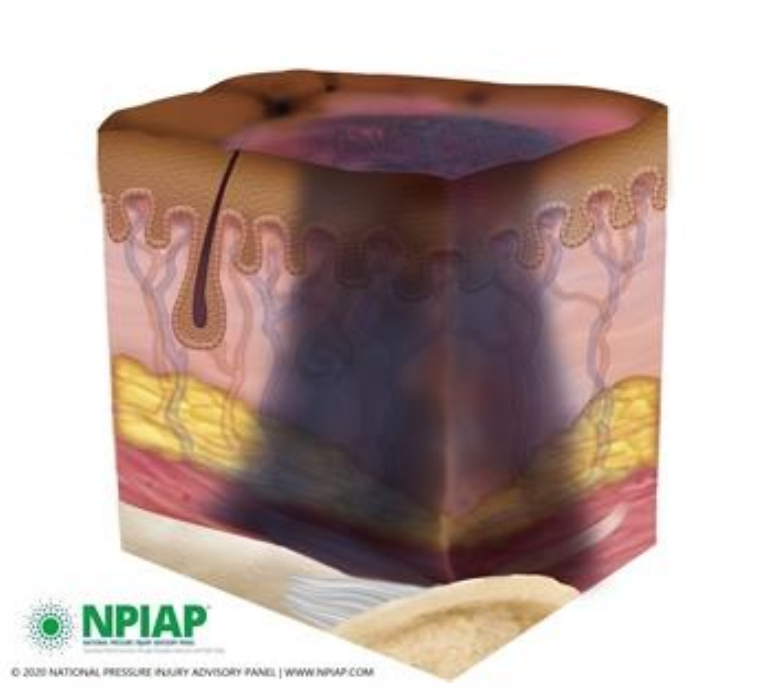
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. • The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

Suspected Deep Tissue Injury: Depth Unknown

Deep Tissue Pressure Injury



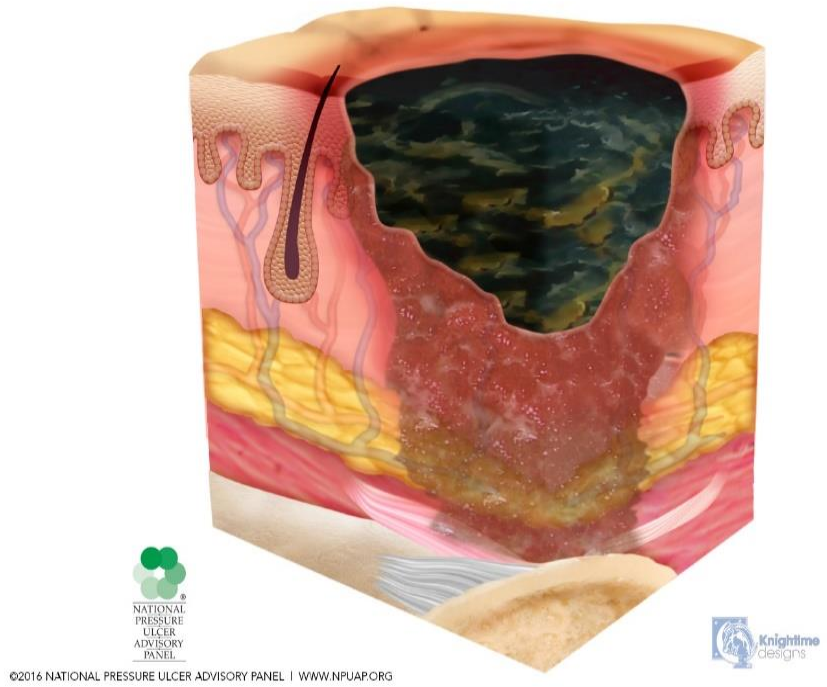
Deep Tissue Pressure Injury - Darkly Pigmented



Purple or maroon localized area or discolored, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. • Deep tissue injury may be difficult to detect in individuals with dark skin tone. • Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Staging Pressure Injuries - Unstageable

Unstageable Pressure Injury – Dark Eschar

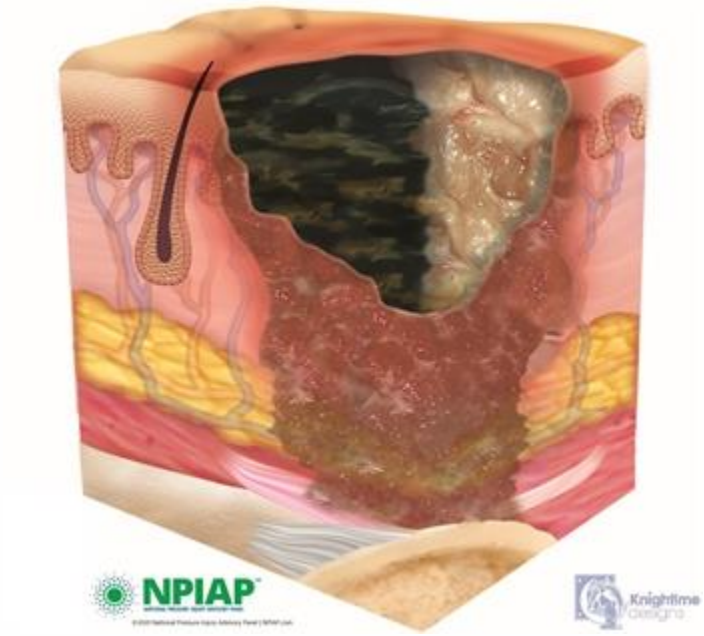


Unstageable Pressure Injury - Dark Skin

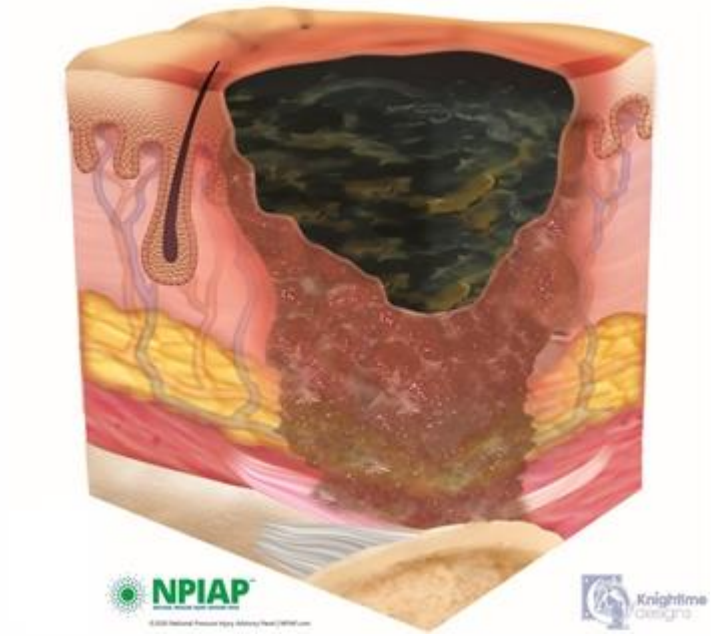
Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed. • Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.

Unstageable Pressure Injury slough and eschar

Unstageable PI slough and eschar



Unstageable PI dark eschar



Slough: **soft moist avascular, devitalized (dead) tissue**. It may be white, yellow, tan, gray or green, and it may be loose or firmly adherent. Slough may be seen in clumps, scattered, or completely covering a wound base. Its presence indicates tissue injury of stage III or higher-pressure injuries.

The presence of eschar should be a red flag for a serious bed sore injury, but the eschar in and of itself is not dangerous for the patient.

Blood flow in the tissue under the eschar **is poor** and the wound is susceptible to infection. The eschar acts as a natural barrier to infection by keeping the bacteria from entering the wound.

ESCHAR DEFINITION

- Eschar, pronounced es-CAR, is dead tissue that sheds or falls off from the skin. It's commonly seen with pressure ulcer wounds (bedsores). Eschar is typically tan, brown, or black, and may be crusty.
- Wounds are classified into stages based on how deep they are and how much skin tissue is affected. When a wound has eschar on top of it, the wound can't be classified. This is because eschar is dead, dark tissue that makes it difficult to see the wound underneath.
- Pictured right is an eschar from a pressure ulcer. Eschars result from tissue necrosis and death; they are usually black and dry. They can be firmly adherent to the wound or lifting. Eschars also result from burns; especially thermal or electric burns.

CARE "Stand Alone" High Risk Indicators

1. Current Pressure Injury
2. Quadriplegia-paralysis of all four limbs
3. Paraplegia- paralysis of the legs and lower body, typically caused by spinal injury or disease.
4. Total dependence in bed mobility
5. Comatose or Persistent Vegetative State
6. History of pressure Injuries within year

CARE "Combination" High Risk Indicators

1. **Bedfast and/or chairbound, and cognition problems**
2. **Bedfast and/or chairbound, and incontinent of bowel or bladder**
3. **Hemiplegia (paralysis of one side of the body) and cognition problems, and incontinent of bowel or bladder**
4. **Bedfast and/or chairbound, and IDDM (Insulin Dependent Diabetes Mellitus (Type 1)**

Three Scenario Types

- Observation Required
- Observation Not Required
- Observation Delayed

Nursing Observation Visit REQUIRED

Clients who meets the highest risk indicators; and neither a non-professional or a professional are providing care that has been documented as meeting the client's needs.

***** This is one of the audit questions and your documentation will be reviewed.**

Observation Visit NOT Required Because…

- **Client does not meet the highest risk indicators**
- **If needed consult or refer to the nurse for other Nursing Services Triggered Critical Indicators.**

***** This is an HCS policy only. DDA has a separate policy, please check with DDA if you have a DDA client.**

Are There Exceptions to Timeframes When Observation May Be Delayed

- ✓ Unsafe situation or inappropriate behaviors.
- ✓ The client requests a shorter or longer activity time.
- ✓ The client is not available for consultation or visit.
- ✓ Immobility of the client does not allow observation.
- ✓ The client meets the highest risk indicators, but an observation was not completed due to culture or gender issue.

What will you document?

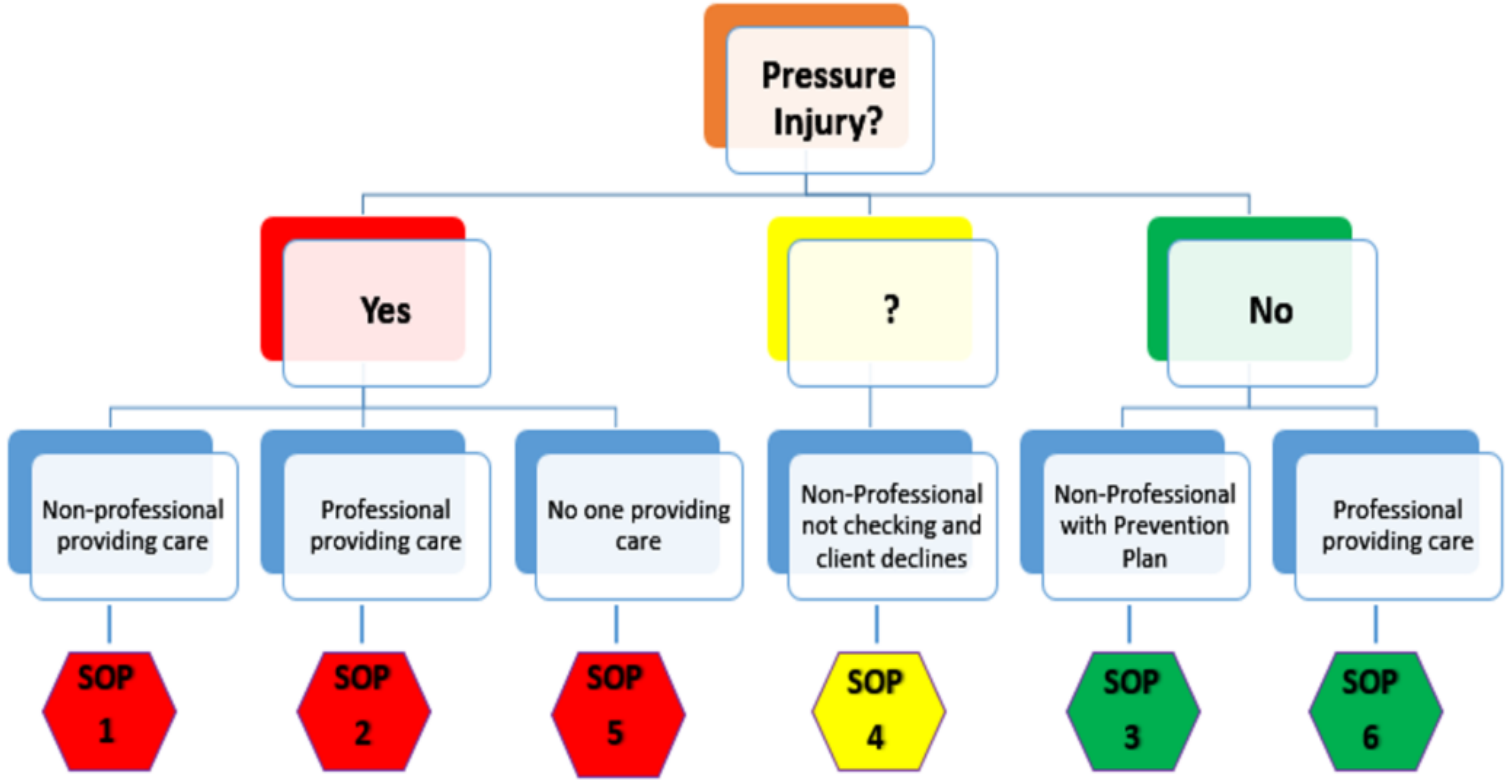
****Keeping each other updated and informed of progress or concerns should be our goal.**

A COPY OF THE FULL SOP CHEAT SHEET IS AVAILABLE . PLEASE SEND REQUEST TO SUSAN.WORTHINGTON@DSHS.WA.GOV.

SOP CHEAT SHEET

A Quick Look at Referrals:

This guide is to be used with the attached SOP Referral Cheat Sheet and will assist you in establishing which SOP template to use at first glance.



SOP 1

Referral Timeframes, Follow Up, And Documentation Requirements

SOP #	Situation	CM Referral	Timeframe Requirements	Required Case Manager or CNC Procedure After Referral	SOP Canned Language to use in Comments Section Of Health Indicators – Per Policy
1	**PRESSURE INJURY? YES** **NON PROFESSIONAL PROVIDING CARE** *A non-professional is providing skin care (treatment) for a client who has a pressure injury.*	**Refer to CNC**	**Same Day As Discovery**	**CNC to:** a. Review the treatment with the caregiver and the client; b. Document what is being done and who authorized treatment; c. Verify by asking the caregiver that he/she is checking all pressure points; d. Distribute educational materials and prevention plans as appropriate related to pressure points to the caregiver and client (pictures or text); e. Revise the plan as needed; f. Document all activities in CARE. **CM to:** a. Follow the Skin Care Cheat Sheet to ensure the Assessment meets QA Standards. b. HCS/AAA/DDA social worker will follow up on RN recommendations.	**CNC Notes:** The client and/or caregiver contacted [name] on [date/time] for **review** of treatment being provided to pressure injury(s) located at [location(s) of pressure injury(s)]. The **treatment plan** includes: [Pressure Injury location], [description of treatment] [Pressure Injury location], [description of treatment] [Pressure Injury location], [description of treatment] (repeated as needed for each pressure injury) The pressure injury treatment was **authorized by** [HCP name(s)].

SOP 2

Referral Timeframes, Follow Up, And Documentation Requirements

SOP #	Situation	CM Referral	Timeframe Requirements	Required Case Manager or CNC Procedure After Referral	SOP Canned Language to use in Comments Section Of Health Indicators – Per Policy
2	**PRESSURE INJURY? YES** **PROFESSIONAL PROVIDING CARE** *A professional is providing skin care (treatment) for a client who has a pressure ulcer.*	**Verify Care Plan with HCP** *(i.e. RN, MD, ARNP, SNF, Hospital, PCP, Nurse Delegator, Home Health Nurse, etc.)*	**5 working days**	**CM to:** a. Verify with the health care professional that: i. There is a treatment plan in place; and ii. The client's skin has been seen by the Health Care Professional (HCP) responsible for treatment according to timeframes recommended in the treatment plan or within the last 7 days. b. Communicate with the HCP, as soon as possible, but not to exceed 5 working days, to: i. Verify that all pressure points are being checked and discuss response to treatment; ii. Request to be notified when client is discharged from care for pressure injuries. At that time, consult with Nursing Services resources; iii. Document all activities in CARE. c. Follow the Skin Care Cheat Sheet to ensure the Assessment meets QA Standards.	**CM or CNC notes:** Verified with [Health Care Provider Name (HCP)] that a treatment plan is in place for the client's pressure ulcer(s). The client is receiving treatment to [location of the ulcer(s)] from [HCP name] [frequency of the treatment - x/week, x/day, etc.]. The client's pressure ulcer(s) have been observed by the HCP on [insert the most recent date of observation]. The client's HCP reports the client's pressure injuries are [insert healing, not healing, granulating, etc.] and the treatment will be () on [date]. The HCP () observing all pressure points. Requested to be notified when client is discharged from care for pressure injuries.

SOP 3

Referral Timeframes, Follow Up, And Documentation Requirements

SOP #	Situation	CM Referral	Timeframe Requirements	Required Case Manager or CNC Procedure After Referral	SOP Canned Language to use in Comments Section Of Health Indicators – Per Policy
	PRESSURE INJURY? NO **NON-PROFESSIONAL WITH PREVENTION PLAN** *A non-professional is providing skin care with a prevention plan in place, the caregiver is checking all of the pressure points, and there is no reported skin problem (After showing F1 Screen to client/rep).*	**Non-Professional** *(i.e. IP/Agency, Hospice Aide, etc.)*	**n/a –** *Document in CARE Per Policy*	**CM or CNC to:** a. Verify that: i. The caregiver, or the client with assistance, as needed, is checking all of the pressure points and all of the pressure points have been checked within the last seven days; ii. The prevention plan is meeting the client's needs, and the client and caregiver have been advised of skin care issues; b. Document what is being done as a prevention plan and who is providing the prevention plan in CARE; c. Use the color pictures included with the protocol as a resource to ask the client or the caregiver regarding the presence of any pictured skin conditions or change; d. Revise the care plan as needed; and e. Document all activities in CARE.	**SW or CNC notes:** Verified with [caregiver name] that he/she is observing all pressure points. All pressure points observed on _____. Verified with the client and/or [caregiver name] that the prevention plans are meeting the client's needs. The client and/or [caregiver name] are **receiving/providing** prevention plans for [insert prevention plans currently in place for Bed Mobility, Bathing, or Toileting]. The client and/or [caregiver name] were shown the **photographs and descriptions of** pressure injuries in F1 and () the presence of any skin changes. (If the client confirms one or more of the pressure ulcer stages present, the case manager must arrange for a Skin Observation visit). The care plan () revised to include the following care needs: [insert suggested revisions to the care plan].

SOP 4

Referral Timeframes, Follow Up, And Documentation Requirements

SOP #	Situation	CM Referral	Timeframe Requirements	Required Case Manager or CNC Procedure After Referral	SOP Canned Language to use in Comments Section Of Health Indicators – Per Policy
4	**PRESSURE INJURY? UNKNOWN** **NON-PROFESSIONAL NOT CHECKING** *A non-professional is providing skin care, the caregiver is NOT checking all of the pressure points, it is not known if there is a problem, the client is cognitively intact, AND the client declines observation.*	**CNC Or *Other HCP* (i.e. RN, MD, ARNP, SNF, Hospital, PCP, Nurse Delegator, Home Health Nurse, etc.)**	**Staff with Supervisor and CNC for Appropriate Action.**	**CM or CNC to:** a. Probe for reasons the client doesn't want skin observed. b. Suggest appropriate alternatives (such as asking if the client has checked their pressure points themselves or if another support person is reliable; have they checked?). c. Use the color pictures included with the protocol as a resource to ask the client or caregiver regarding the presence of any of the pictured skin conditions or changes. d. Document in CARE and: i. Refer to the HCS/AAA/DDA nurse or other contracting nursing resources for follow up; or ii. Contact the client's primary care provider as soon as possible, discuss skin concerns and document; or iii. Advise the client of skin care issues, educate and document; and e. Do not complete skin observation. f. Document in CARE, on the appropriate screen(s), that the client has declined skin observation and follow CARE assessment and service planning procedures. g. Discuss with your supervisor (to ensure case is accurate per policy.	**CM or CNC Notes:** The client is declining observation of pressure points. Reasons stated by the client for declination are: [insert reasons for declining observation]. The photographs and descriptions of pressure injuries were shown to the client and/or [caregiver name] and the client and/or [caregiver name] () the presence of any skin changes. The client was referred to Nursing Services for follow-up in relation to [insert reason for follow-up] **OR** Case manager contacted the client's primary care provider and discussed skin concerns including [list skin issues/concerns discussed with health care provider]. Or The client was **advised** of skin care issues by [name] and educated using **educational materials** provided to the client and/or caregiver: [list all that were provided and/or reviewed]: (Maintaining Healthy Skin Part 1; Maintaining Healthy Skin Part 2; Taking Care of Pressure Sores; Fundamentals of Caregiving Skin and Body Care modules; and CARE Prevention Plans (Bed Mobility; Bathing; Toileting; Diagram of Pressure Points). Discussed, with my supervisor, the clients declination of skin observation and [list contacts made, referrals made, education provided, etc.] to the client and [caregiver name].

SOP 5

Referral Timeframes, Follow Up, And Documentation Requirements

SOP #	Situation	CM Referral	Timeframe Requirements	Required Case Manager or CNC Procedure After Referral	SOP Canned Language to use in Comments Section Of Health Indicators – Per Policy
5	**PRESSURE INJURY? YES** **NO ONE PROVIDING CARE** *There is a Current Pressure Injury, No one is providing skin care that has been verified as meeting the client's needs.*	**CNC**	**Same Day As Discovery**	**CM to:** a. Refer client to CNC to complete observation. b. Document all activities in CARE. c. Follow the Skin Care Cheat Sheet to ensure the Assessment meets QA Standards. d. Read CNC's documentation. Follow up on recommendations and document reviewing and completing tasks assigned to SW.	**CNC Notes:** See the following four slides for detailed RN observation note for SOP 5.

SOP 5- RN OBSERVATION NOTE

The client meets the highest risk indicators, and no one (neither professional or non-professional) is providing skin care that has been verified as meeting the client's needs. Refer the client to the HCS/AAA/DDD Nurse or other contracting nursing resources to complete the observation.

Nurse Note:

Referral received from [referent name] to provide Skin Observation visit to the client. Called the client on [date] to arrange an observation visit. The client (did/did not) want to have a **third-party present** during the observation visit. (If a third party is needed, document contact with that person for arrangement of the visit).
Document in SER or on Skin Observation/Skin Screen:
Skin Observation completed with [names of other persons present]. All pressure points observed (head, ears, shoulder blades, elbows, knees (medial and lateral), sacrum, coccyx, ischial tuberosities, hops, ankles (medial and lateral) and heels). Observed the following skin changes [insert description of any areas with changes)
Any noted skin changes with locations (basic skin assessment):

- Temperature
- Color
- Moisture
- Turgor
- Integrity
- Nails
- Hair
- Moles
- Injury

Pressure points observed [insert any alterations from intact].

SOP 5- RN OBSERVATION NOTE, Cont.

The client meets the highest risk indicators, and no one (neither professional or non-professional) is providing skin care that has been verified as meeting the client's needs. Refer the client to the HCS/AAA/DDD Nurse or other contracting nursing resources to complete the observation.

Nurse Note:

Pressure injury observed

The documentation for each pressure injury observed should include the following detail in the CARE documentation:

- Location
- Classification
- Measurement
- Wound pain
- Wound exudate-amount and character
- Surrounding skin
- Tunneling
- Undermining
- Wound bed
- Additional descriptions/comments

SOP 5- RN OBSERVATION NOTE

The client meets the highest risk indicators, and no one (neither professional or non-professional) is providing skin care that has been verified as meeting the client's needs. Refer the client to the HCS/AAA/DDD Nurse or other contracting nursing resources to complete the observation.

Nurse Note:

Referral received from [referent name] to provide Skin Observation visit to the client. Called the client on [date] to arrange an observation visit. The client (did/did not) want to have a **third-party present** during the observation visit. (If a third party is needed, document contact with that person for arrangement of the visit).
Document in SER or on Skin Observation/Skin Screen:
Skin Observation completed with [names of other persons present]. All pressure points observed (head, ears, shoulder blades, elbows, knees (medial and lateral), sacrum, coccyx, ischial tuberosities, hops, ankles (medial and lateral) and heels). Observed the following skin changes [insert description of any areas with changes)
Any noted skin changes with locations (basic skin assessment):

- Temperature
- Color
- Moisture
- Turgor
- Integrity
- Nails
- Hair
- Moles
- Injury

Pressure points observed [insert any alterations from intact].

SOP 5- RN OBSERVATION NOTE, Cont.

The client meets the highest risk indicators, and no one (neither professional or non-professional) is providing skin care that has been verified as meeting the client's needs. Refer the client to the HCS/AAA/DDD Nurse or other contracting nursing resources to complete the observation.

Nurse Note:
If a skin problem is observed:

Contact made by (phone/fax) with [list the contact names and relationship to the client] to discuss finding of Skin Observation visit and [list current or required treatment or prevention plans] for this client.

Decisions/referrals made regarding care and treatment needed by client include [document treatment decisions and who is responsible].

The care plan (was)/was not) **revised** to include the following care needs: [insert suggested revisions to care plan including a prevention plans]

SOP 5- RN OBSERVATION NOTE, Cont.

The client meets the highest risk indicators, and no one (neither professional or non-professional) is providing skin care that has been verified as meeting the client's needs. Refer the client to the HCS/AAA/DDD Nurse or other contracting nursing resources to complete the observation.

Nurse Note:

If **NO** skin problem is observed:

Contact made by (phone/fax) with [list the contact names and relationship to the client] to discuss finding of Skin Observation visit and [list current or required treatment or prevention plans] for this client.

Decisions/referrals made regarding care and treatment needed by client include [document treatment decisions and who is responsible].

The care plan (was)/was not) **revised** to include the following care needs: [insert suggested revisions to care plan including a prevention plans]

SOP 6

Referral Timeframes, Follow Up, And Documentation Requirements

SOP #	Situation	CM Referral	Timeframe Requirements	Required Case Manager or CNC Procedure After Referral	SOP Canned Language to use in Comments Section Of Health Indicators – Per Policy
6	**PRESSURE INJURY? NO** **PROFESSIONAL PROVIDING CARE** *There is NOT a current pressure ulcer and a professional is providing skin care with a prevention plan and the professional is checking all pressure points*	**Verify Care Plan with HCP** *(i.e. RN, MD, ARNP, SNF, Hospital, PCP, Nurse Delegator, Home Health Nurse, etc.)*	**5 working days**	**CM to:** a. Verify with the health care professional that: i. There is a treatment plan in place; and ii. The client's skin has been seen by the Health Care Professional (HCP) responsible for treatment according to timeframes recommended in the treatment plan or within the last 7 days. b. Communicate with the HCP, as soon as possible, but not to exceed 5 working days, to: i. Verify that all pressure points are being checked and discuss response to treatment; ii. Request to be notified when client is discharged from care for pressure injuries. At that time, consult with Nursing Services resources; iii. Document all activities in CARE.	**SW or CNC notes:** Verified with [professional name and title of (facility's name)] that he/she is observing all pressure points. All pressure points observed on _____ (within the last 24hours). Verified with the client and/or [professional name] that the prevention plans are meeting the client's needs. The [client and/or professional name] are receiving/providing prevention plans for [insert prevention plans currently in place for Bed Mobility, Bathing, or Toileting]. The [client and/or professional name] were shown the photographs and descriptions of pressure injuries in F1 and denies the presence of any skin changes. After meeting with the [professional name and title of (facility's name)], the care plan (was/was not) revised to include the following care needs: [insert suggested revisions to the care plan].

Skin Observation Delayed - Process
When Cognitively Impaired

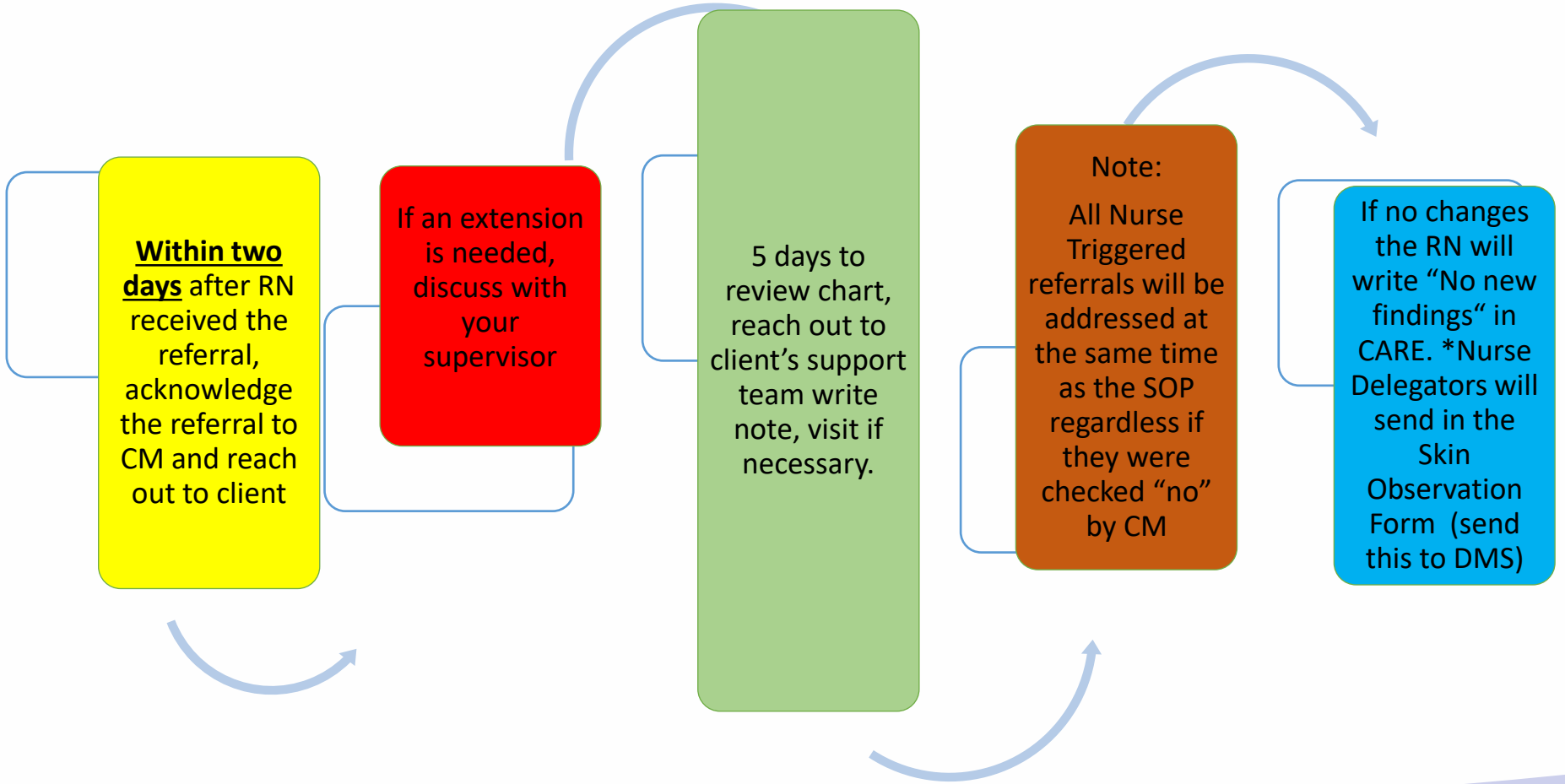
- Refer to the “Challenging Cases Protocol” (see LTC Manual Chapter 5 Case Management);
- Refer to and consult with your supervisor regarding other services;
- Offer alternative services, a different provider, a residential placement or a change in the way services are delivered;

- Probe to understand the basis of refusal;
- Refer to APS, CPS or CRU if there are allegations of abuse, neglect or self-neglect;
- Refer to 911, ER, or CDMHPs, if appropriate, for involuntary treatment;

- Refer for guardianship with AAG involvement, if appropriate; and Document all activities.

When should the RN?

RN Response Time & Documentation



Within 2 Working Days-from receipt of referral

- ***The Nurse*** contacts the client's HCP to determine if the HCP is involved and treating the skin
- If client has no HCP or is refusing treatment, ***the Nurse*** contacts the family representative
- ***The Nurse*** must provide the case manager documentation of all steps taken

Exception Disclaimer

- **Exception: If you determine that the non-professional care being provided through the prevention plan is inadequate or is not meeting the needs of the client, a nurse must make an observation visit and revise care plan, as necessary.**

  - **Make Observation**
  - **Complete Form 13-783**
  - **Complete 13-780**

SOP REFERRAL FORM #13-776-filled out by CM

HCS # 13-776

- Items 1-9; 14
  - Basic Background Information
- Item 10-11
  - Referral Request Activity
    - SOP with visit
  - Activity Frequency
- Item 12- Care Triggered Referrals Reason for Request
- Item 13 Special Instructions
- Confirmation of Receipt and Acceptance of referral

HCS / AAA Nursing Services Referral

1. REFERRED TO RN PROVIDER / AGENCY / DELEGATOR: NAME	TELEPHONE NUMBER		2. DSHS OFFICE ☐ HCS ☐ AAA
FAX NUMBER	EMAIL ADDRESS		DATE OF REFERRAL
3. CLIENT NAME (LAST, FIRST, MI)			
DATE OF BIRTH	TELEPHONE NUMBER	PROVIDER 1 NUMBER	ACES NUMBER
4. CLIENT ADDRESS	CITY	STATE	ZIP CODE
5. CAREGIVER NAME (LAST, FIRST, MI)	6. AGENCY NAME (IF AGENCY CAREGIVER)		TELEPHONE NUMBER
7. CONTACT NAME (IF DIFFERENT THAN CAREGIVER)			TELEPHONE NUMBER
8. CONTACT RELATIONSHIP TO CLIENT	9. GUARDIAN NAME (IF ANY)		TELEPHONE NUMBER

10. Referral Request

10. Requested Activity (check all that apply)	11. Activity Frequency (days/week times per week / month / year)
☐ Nursing Assessment/Reassessment (visit)	Frequency Duration of Activity:
☐ Instruction to client and/or Providers (visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (with visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (without visit)	Frequency Duration of Activity:
☐ Evaluation of health related elements of assessment or service plan (without visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (with visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (without visit)	Frequency Duration of Activity:

12. CARE Triggered Referrals Reason for Request (Check all that apply)

☐ Unstable/potentially unstable diagnosis	☐ Current or potential skin problem (not SOP)
☐ Medication regimen affecting plan of care	☐ Skin Observation Protocol
☐ Nutritional status affecting plan of care	☐ Other reason:
☐ Immobility issues affecting plan of care	

13. Special Instructions

☐ Requesting visit be made with case manager	☐ Request visit with Caregiver
☐ Consult with case manager before contacting client or caregiver	☐ Caregiver Training Requested
	☐ Interpreter Required for _____ language
☐ Additional Comments:	

14. SW / CASE / MANAGER	E-MAIL ADDRESS	FAX NUMBER
SW / CASE / MANAGER TELEPHONE NUMBER		DATE

IMPORTANT: Please be sure to Fax current CARE Assessment, Service Summary and Release of Information form if the nursing resource does not have access to CARE.

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

☐ Referral received	Date Received:	☐ Additional Comments:
☐ Referral accepted		
☐ Referral not accepted Reason: _____		
☐ Nurse Assigned: Telephone Number:		

HCS# 13-776

13. Special Instructions	
☐ Requesting visit be made with case manager	☐ Request visit with Caregiver
☐ Consult with case manager before contacting client or caregiver	☐ Caregiver Training Requested
	☐ Interpreter Required for _____ language
☐ Additional Comments:	

FORM #13-780-Filled out at visit

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Nursing Services Basic Skin Assessment (Integumentary System – Skin, Hair, Nail)

DATE OF SERVICE	
CM / RN NAME	
REFERRING RN NAME	

CLIENT NAME	DATE OF BIRTH	CLIENT ACES ID	CLIENT PROVIDER ONE ID

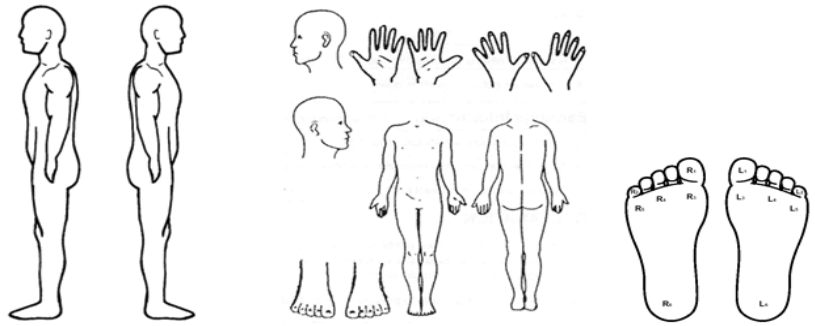
REQUEST RELATED TO **(REQUESTOR COMPLETES)**: CHECK ALL THAT APPLY

- ☐ Skin Observation
- ☐ Other referral type (describe):

Documentation to be sent back to: By: ☐ Fax ☐ Email ☐ Hard Copy

Injuries Assessment Section

Beginning with any pressure injuries, number all integumentary issues consecutively, starting with #1, #2, #3, etc. (Skin, Hair and Nails)



Skin Issues

Specify all types below as numbered / designated above: The number, skin issue type and comments.

Examples of possible types of skin issues from CARE include pressure injuries, abrasions, acne / persistent redness, boils, bruises, burns, canker sore, diabetic ulcer, dry skin, hives, open lesions, rashes, skin desensitized to pain / pressure, skin folds / perineal rash, skin growths / moles, stasis ulcers, sun sensitivity, and surgical wounds. Please note there are many other skin issues not mentioned here such as irregular skin area such as boggy or mushy skin area, discoloration area(s).

Please note: Any current pressure injuries require further detailed documentation on Pressure Ulcer Assessment and Documentation, form DSHS 13-783.

NUMBER	SKIN ISSUE TYPE AND LOCATION	COMMENTS (PROVIDE FURTHER (NON-PRESSURE INJURY) DOCUMENATION IN ADDITIONAL NOTES SECTION. FURTHER PRESSURE INJURY DOCUMENTATION REQUIRES FORM DSHS 13-783.)

NURSING SERVICES BASIC SKIN ASSESSMENT
DSHS 13-780 (REV. 01/2017)

Page 1 of 2

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Nursing Services Basic Skin Assessment (Integumentary System – Skin, Hair, Nail)

DATE OF SERVICE	
CM / RN NAME	
REFERRING RN NAME	

CLIENT NAME	DATE OF BIRTH	CLIENT ACES ID	CLIENT PROVIDER ONE ID

Basic Skin Assessment – Additional Detail (Check – Off and Notes)

CONSIDER HISTORY OF SKIN CONDITION

- How long has the condition been present?
- How often does it occur or recur?
- Are there any seasonal variations?
- Is there a family history of skin disease?
- Any habits, behaviors or hobbies or other affecting the skin?
- What medication is client taking?
- Any known allergies?
- Include previous and present treatments and their effectiveness.

Color: ☐ Pale ☐ WNL ☐ Cyanotic ☐ Jaundice ☐ Other (describe):
Notes:

Temperature: ☐ Afebrile ☐ Warmer than normal (febrile) ☐ Other (describe):
Notes:

Turgor: ☐ Normal ☐ Slow (tenting)
Notes:

Any foul odor: ☐ Yes ☐ No
Notes:

Moisture: ☐ WNL ☐ Dry ☐ Diaphoretic ☐ Other (describe):
Notes:

Skin integrity: ☐ WNL / intact ☐ See problem list
Notes:

Moles: ☐ Present
a. Asymmetry ☐ Yes ☐ No
b. Border ☐ Regular ☐ Irregular
c. Color
d. Diameter
Notes: Referral and follow-up for suspect / abnormal or irregular mole:

Hair: ☐ Even distributed ☐ Hair loss ☐ Other (describe):
Notes:

Nails: ☐ WNL ☐ Thickened ☐ Clubbing ☐ Discolored ☐ Other (describe):
Cap Refill: ☐ < 3 sec ☐ > 3 sec
Notes:

Non-injury recommendations to CM / CRM (for follow-up with HCP, treatment, care planning, or other directions):

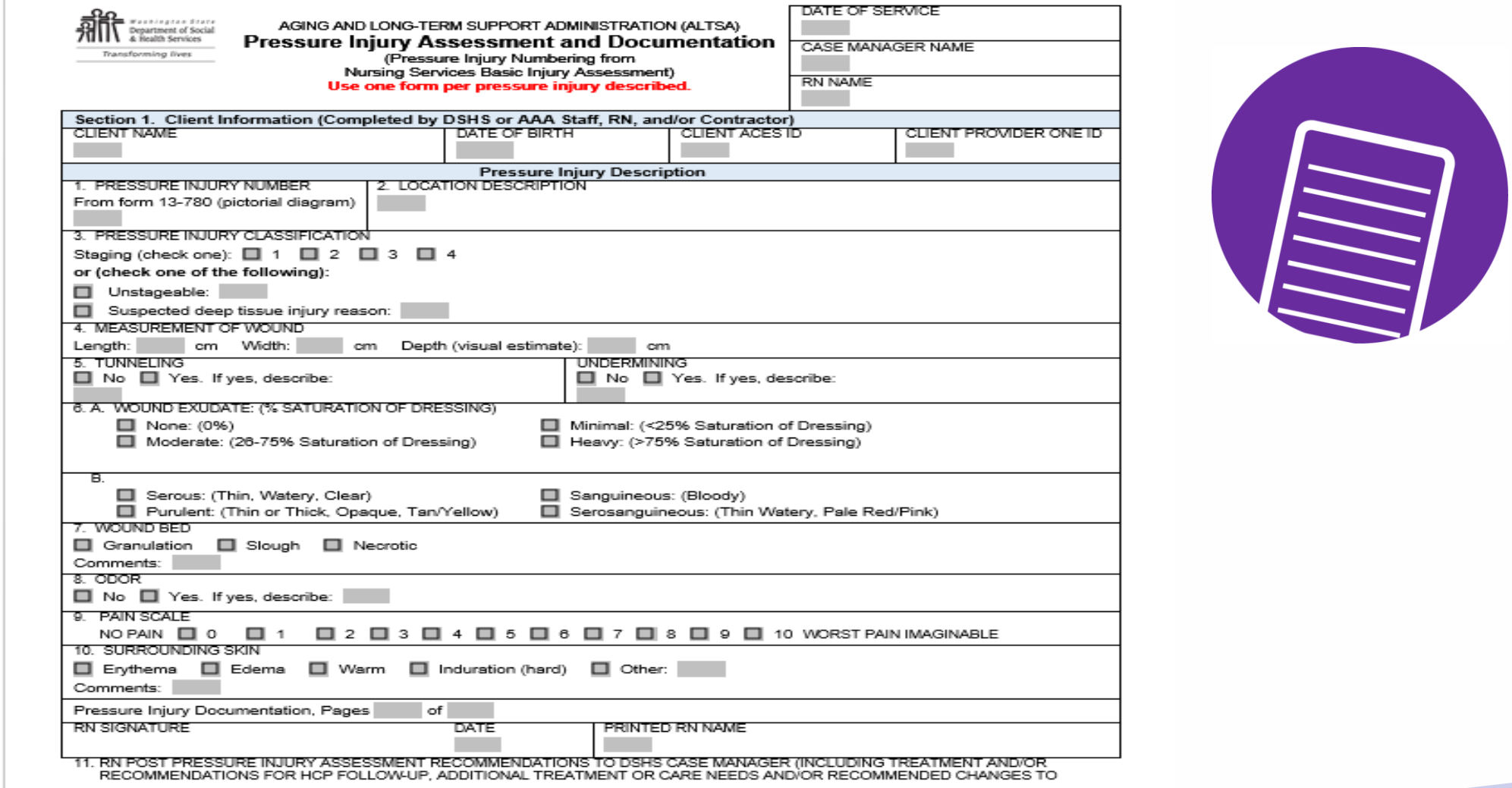
RN SIGNATURE	DATE	PRINTED RN NAME

☐ **Additional forms / documentation attached**

NURSING SERVICES BASIC SKIN ASSESSMENT
DSHS 13-780 (REV. 01/2017)

Page 2 of 2

FORM #13-783- One form for each pressure injury



Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Pressure Injury Assessment and Documentation

(Pressure Injury Numbering from Nursing Services Basic Injury Assessment)

Use one form per pressure injury described.

DATE OF SERVICE

CASE MANAGER NAME

RN NAME

Section 1. Client Information (Completed by DSHS or AAA Staff, RN, and/or Contractor)

CLIENT NAME | DATE OF BIRTH | CLIENT ACES ID | CLIENT PROVIDER ONE ID

Pressure Injury Description

1. PRESSURE INJURY NUMBER From form 13-780 (pictorial diagram)

2. LOCATION DESCRIPTION

3. PRESSURE INJURY CLASSIFICATION

Staging (check one): ☐ 1 ☐ 2 ☐ 3 ☐ 4

or (check one of the following):

☐ Unstageable:

☐ Suspected deep tissue injury reason:

4. MEASUREMENT OF WOUND

Length: cm Width: cm Depth (visual estimate): cm

5. TUNNELING ☐ No ☐ Yes. If yes, describe:

UNDERMINING ☐ No ☐ Yes. If yes, describe:

6. A. WOUND EXUDATE: (% SATURATION OF DRESSING)

☐ None: (0%) ☐ Minimal: (<25% Saturation of Dressing)

☐ Moderate: (26-75% Saturation of Dressing) ☐ Heavy: (>75% Saturation of Dressing)

B.

☐ Serous: (Thin, Watery, Clear) ☐ Sanguineous: (Bloody)

☐ Purulent: (Thin or Thick, Opaque, Tan/Yellow) ☐ Serosanguineous: (Thin Watery, Pale Red/Pink)

7. WOUND BED

☐ Granulation ☐ Slough ☐ Necrotic

Comments:

8. ODOR

☐ No ☐ Yes. If yes, describe:

9. PAIN SCALE

NO PAIN ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 WORST PAIN IMAGINABLE

10. SURROUNDING SKIN

☐ Erythema ☐ Edema ☐ Warm ☐ Induration (hard) ☐ Other:

Comments:

Pressure Injury Documentation, Pages of

RN SIGNATURE | DATE | PRINTED RN NAME

11. RN POST PRESSURE INJURY ASSESSMENT RECOMMENDATIONS TO DSHS CASE MANAGER (INCLUDING TREATMENT AND/OR RECOMMENDATIONS FOR HCP FOLLOW-UP, ADDITIONAL TREATMENT OR CARE NEEDS AND/OR RECOMMENDED CHANGES TO

Prevention Plans

For Clients Who are primarily bedfast:

Do's:

1. Look at the client's skin at least once a day for changes in color or temperature (warmth or coolness), rashes, sores, odor or pain. See diagram on pressure points, and pay special attention to those areas.
2. Assist the client to change position at least every 2 hours.
3. Use pillows or other cushioning to:
    a. Keep bony pressure points from direct contact with the bed;
    b. Raise the heels off the bed; and
    c. Keep the knees and ankles from directly touching one another.
4. When the client is lying on their side, avoid placing them directly on the hipbone. Make sure that bony points are not touching one another, such as the knees and ankles.
5. Raise the head of the bed;
    a. only as much as necessary for comfort and if consistent with other medical conditions and restriction; and
    b. only as long as necessary for eating, grooming, toileting, etc.
    c. Raising the foot of the bed at the same time helps keep the client from sliding down to the bottom of the bed.
6. Lift, don't drag clients who are unable to assist during transfers or positioning,
7. Use special pressure reducing equipment for the bed when available.

Don'ts:

8. **Do not** use donut-type devices purchased at the drug store. These cause more pressure rather than reducing pressure.
9. **Do not** use heat lamps, hair dryers, or "potions" that could dry the skin out more.

Report the following changes to the appropriate person(s) when:

10. The client you are caring for has skin changes, such as redness, swelling, heat or pain, or a break in the skin over a pressure point; or
11. You notice that the heels turn hard and black, or purple and soft; or
12. You are unsure of how to provide care, or if special equipment is needed.

Pamphlets

MAINTAINING HEALTHY SKIN: PART I

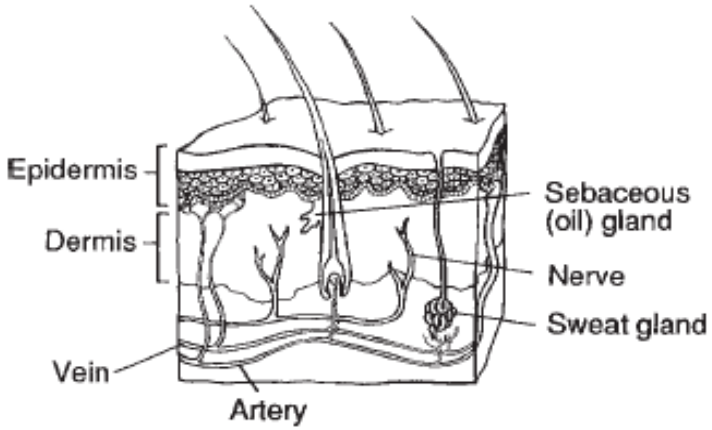
Northwest Regional SCI System

UW Medicine

Department of Rehabilitation Medicine

What is Healthy Skin?

Your skin is much more than an outer surface for the world to see. It protects you from bacteria, dirt and other foreign objects and the ultraviolet rays of the sun, and contains the nerve endings that let you know if something is hot or cold, soft or hard, sharp or dull. Your skin also plays an important role in regulating your body's fluids and temperature.



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For Questions Contact

Susan Worthington, BSN, RN
Nursing Services and Adult Day Services Program Manager
(360) 725-2638
Susan.Worthington@dshs.wa.gov

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