Transforming Lives

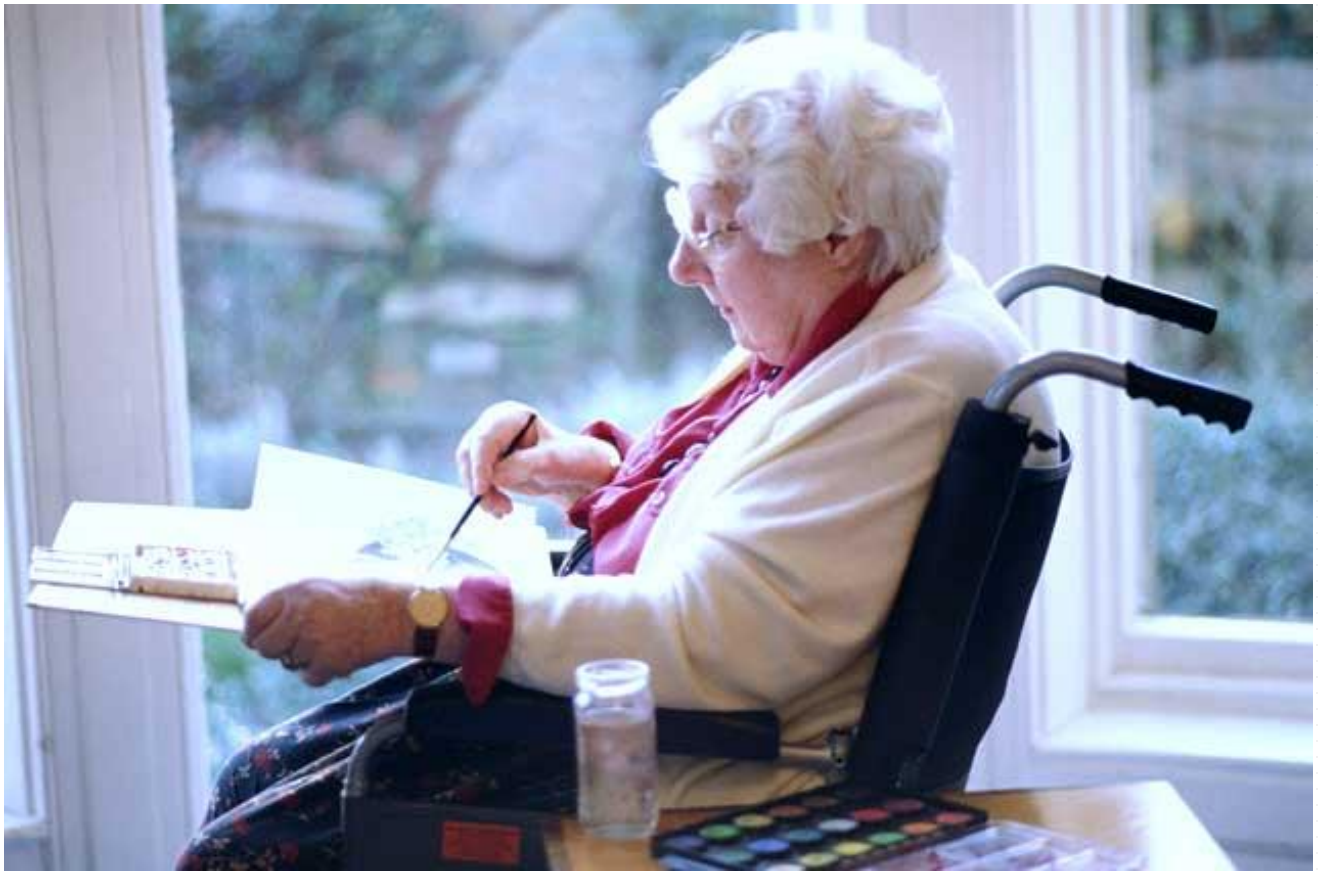
Skin Observation Protocol for Delegating Nurses serving HCS and DDA Clients

Jerome Spearman RN –HCS

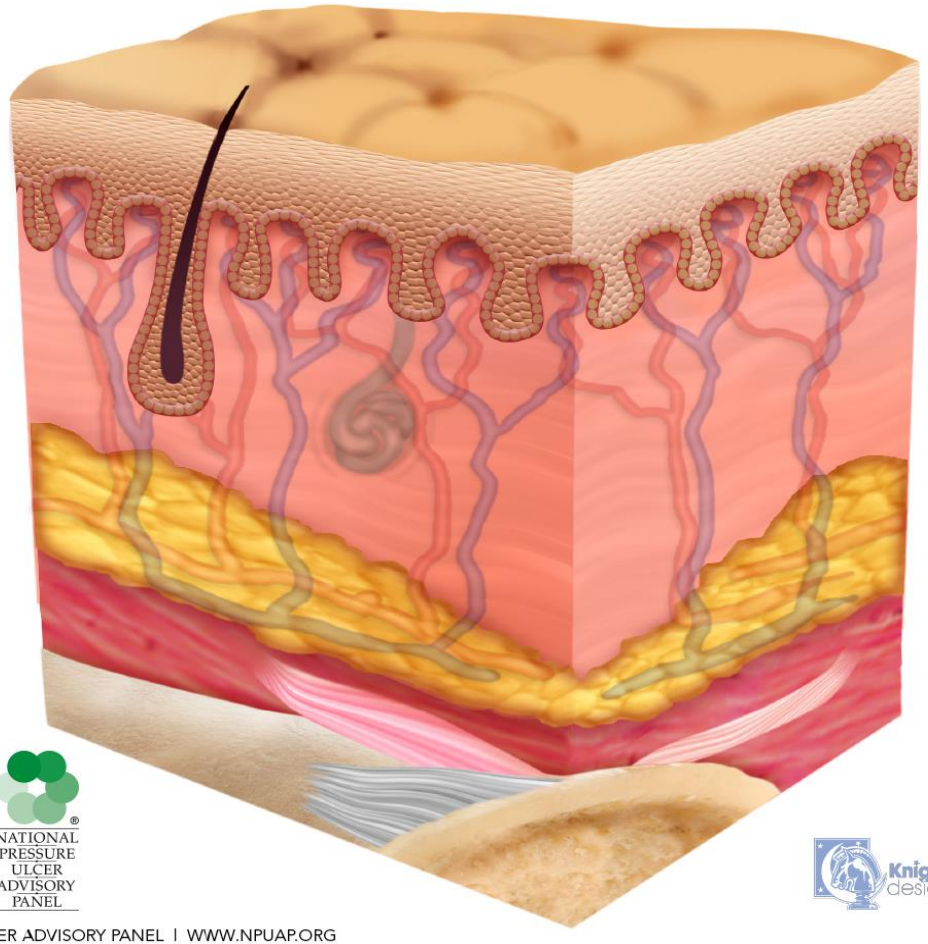
Agenda

- Client Experience
  - CARE Assessment
  - Nursing Triggered Referrals
- Referral Process
    - Skin Observation Protocol
    - Scenarios

Client Experience- Day 1



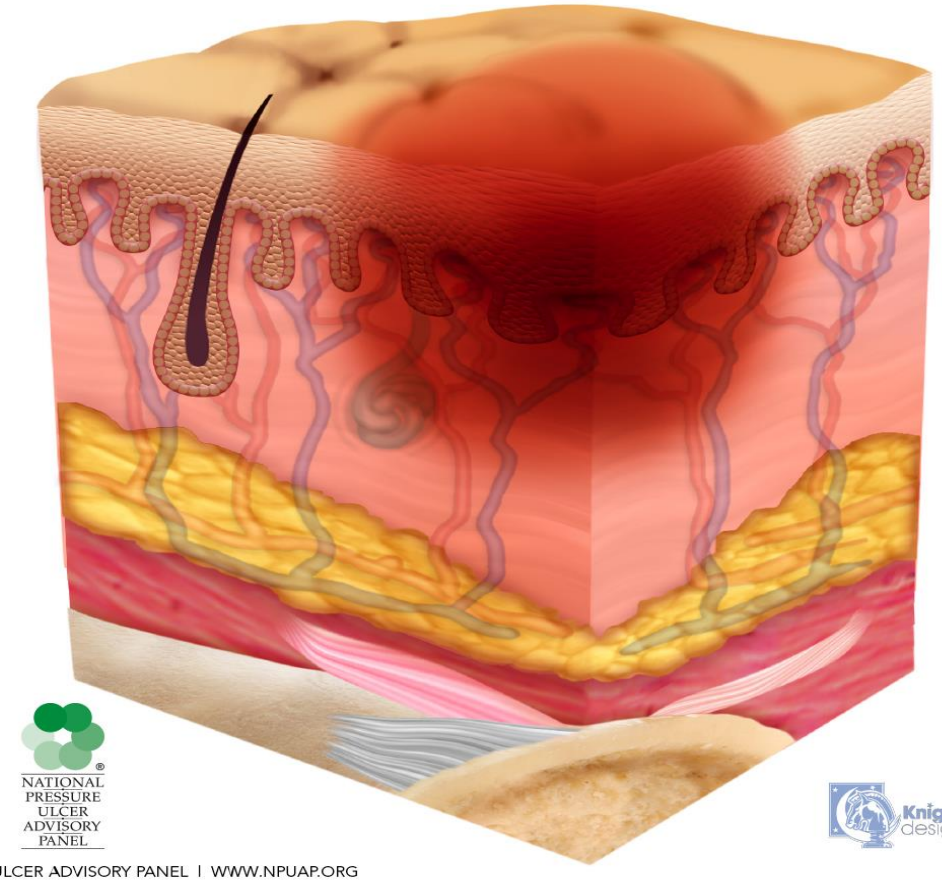
Healthy Skin – Lightly Pigmented



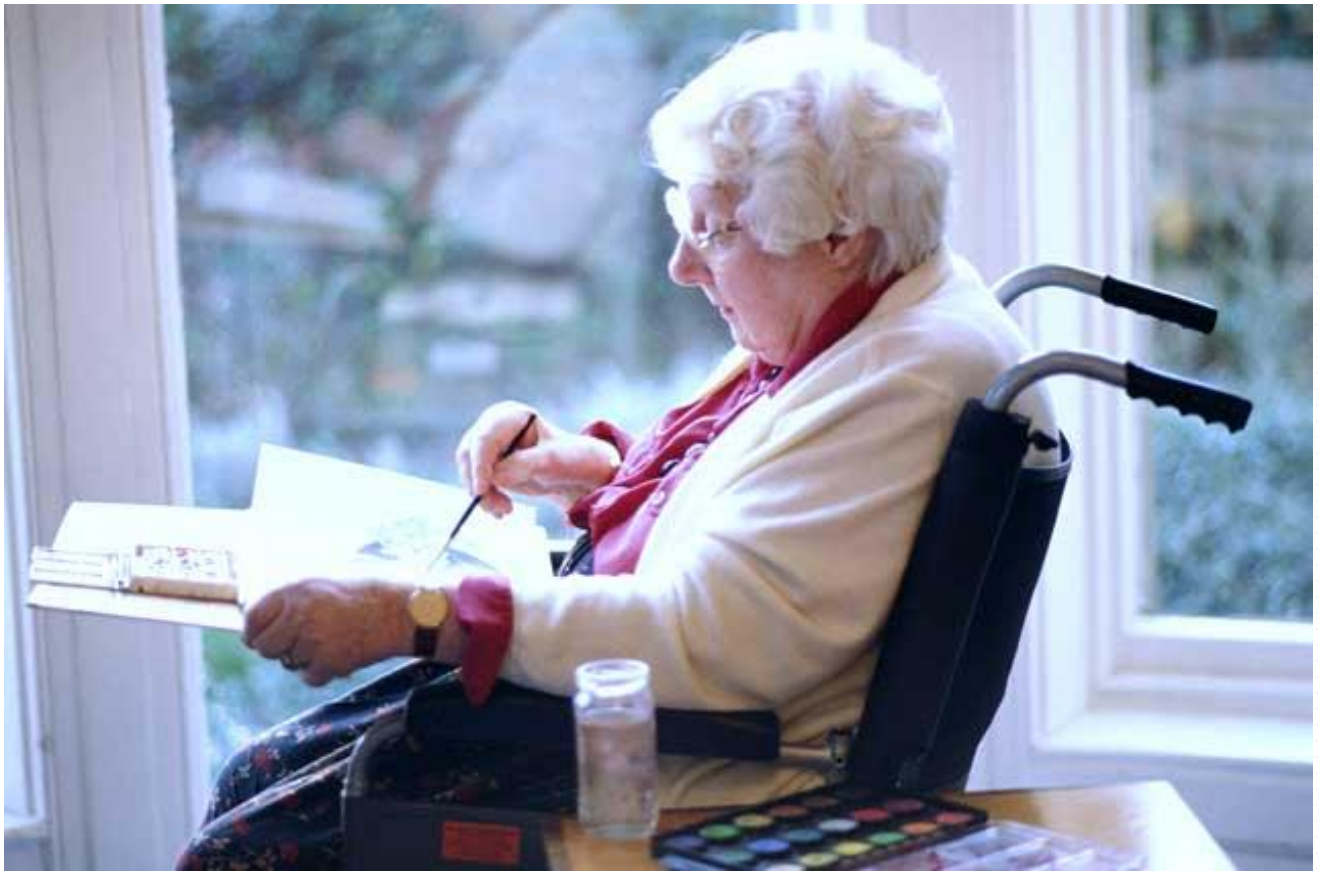
NATIONAL PRESSURE ULCER ADVISORY PANEL

Knightime designs

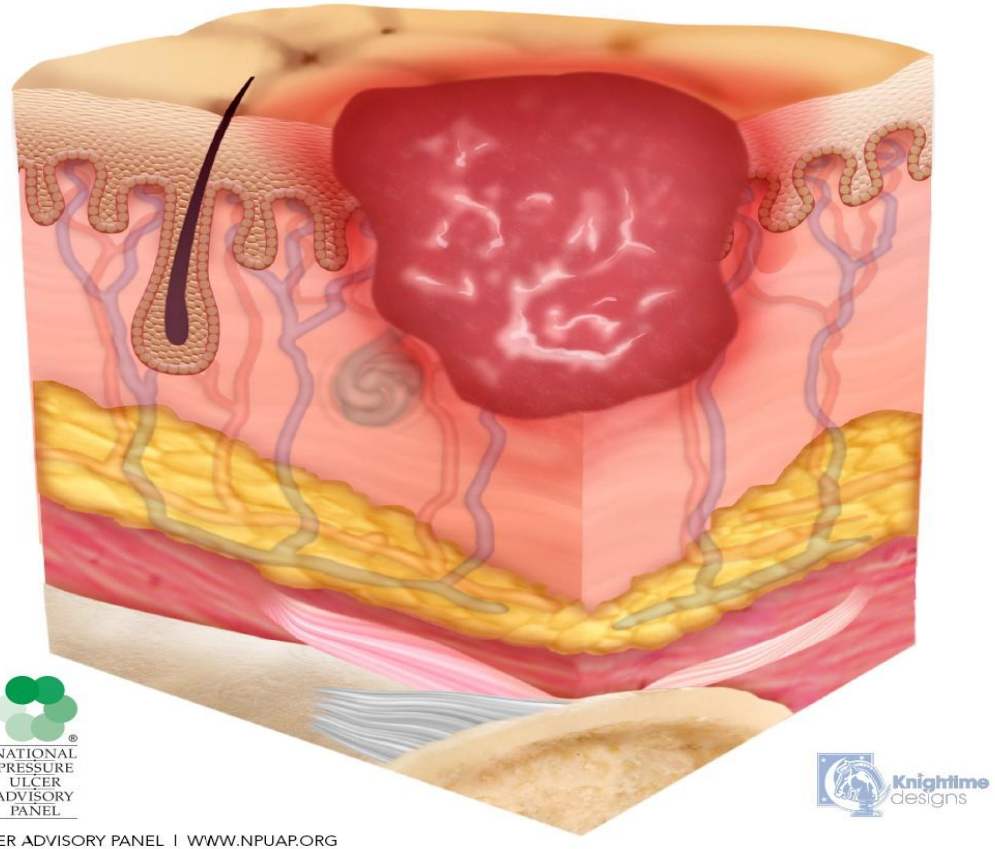
Stage 1 Pressure Injury – Lightly Pigmented



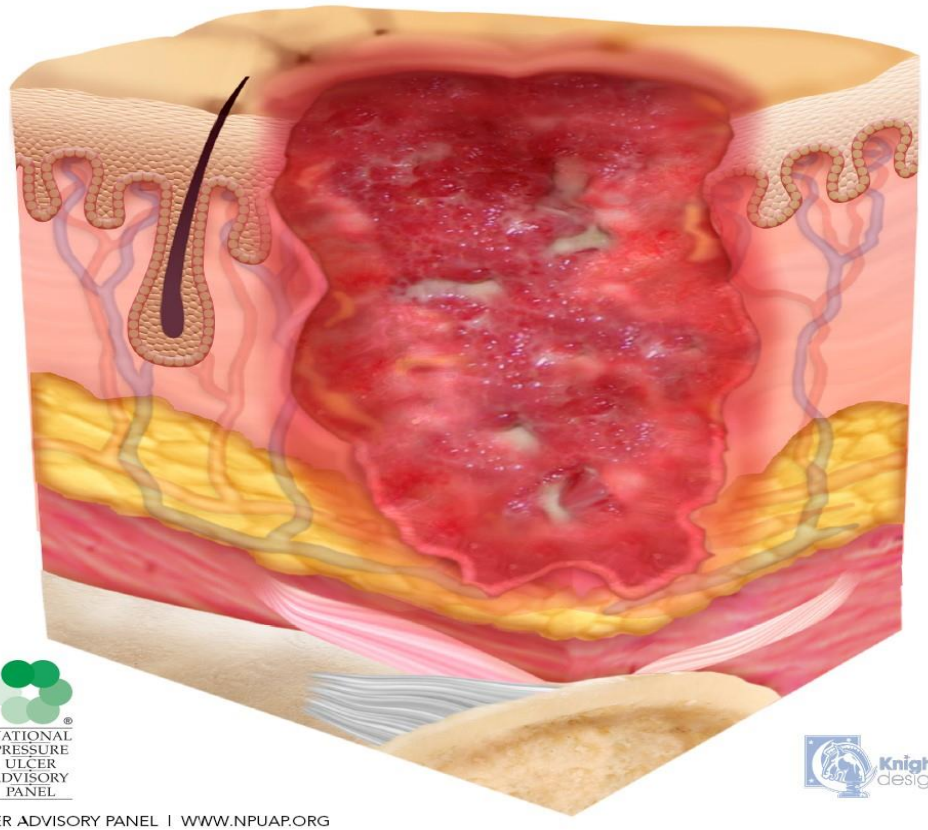
Client Experience- Day 2-3



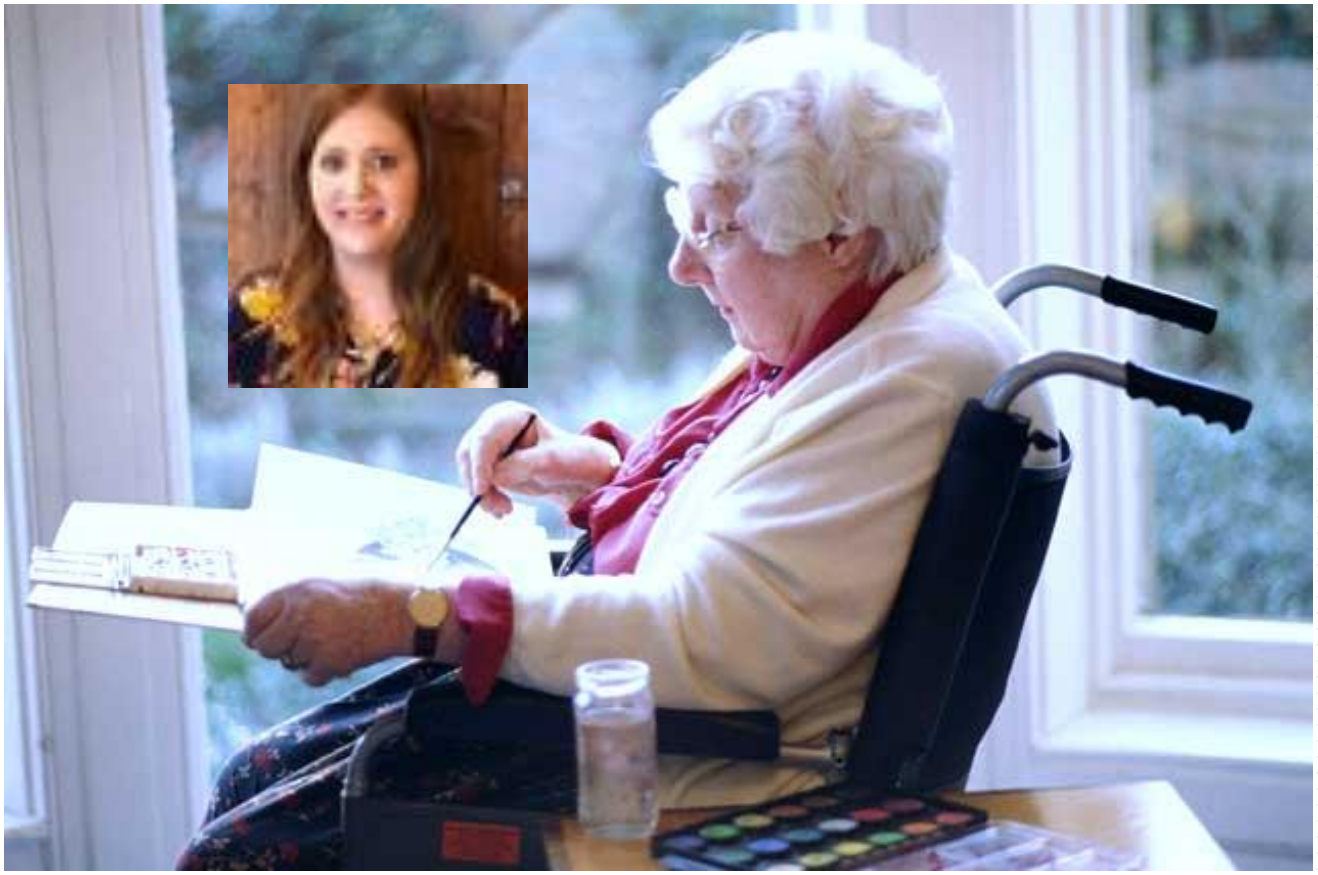
Stage 2 Pressure Injury



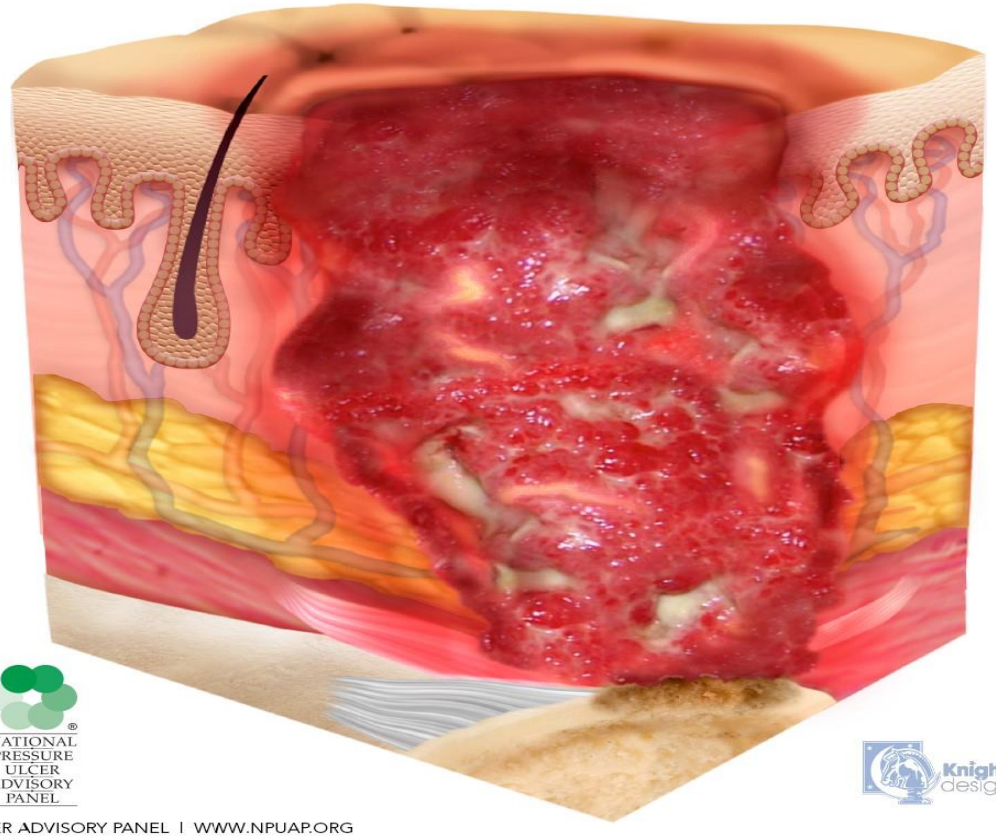
Stage 3 Pressure Injury



Client Experience- Day 3-4



Stage 4 Pressure Injury



NATIONAL PRESSURE ULCER ADVISORY PANEL

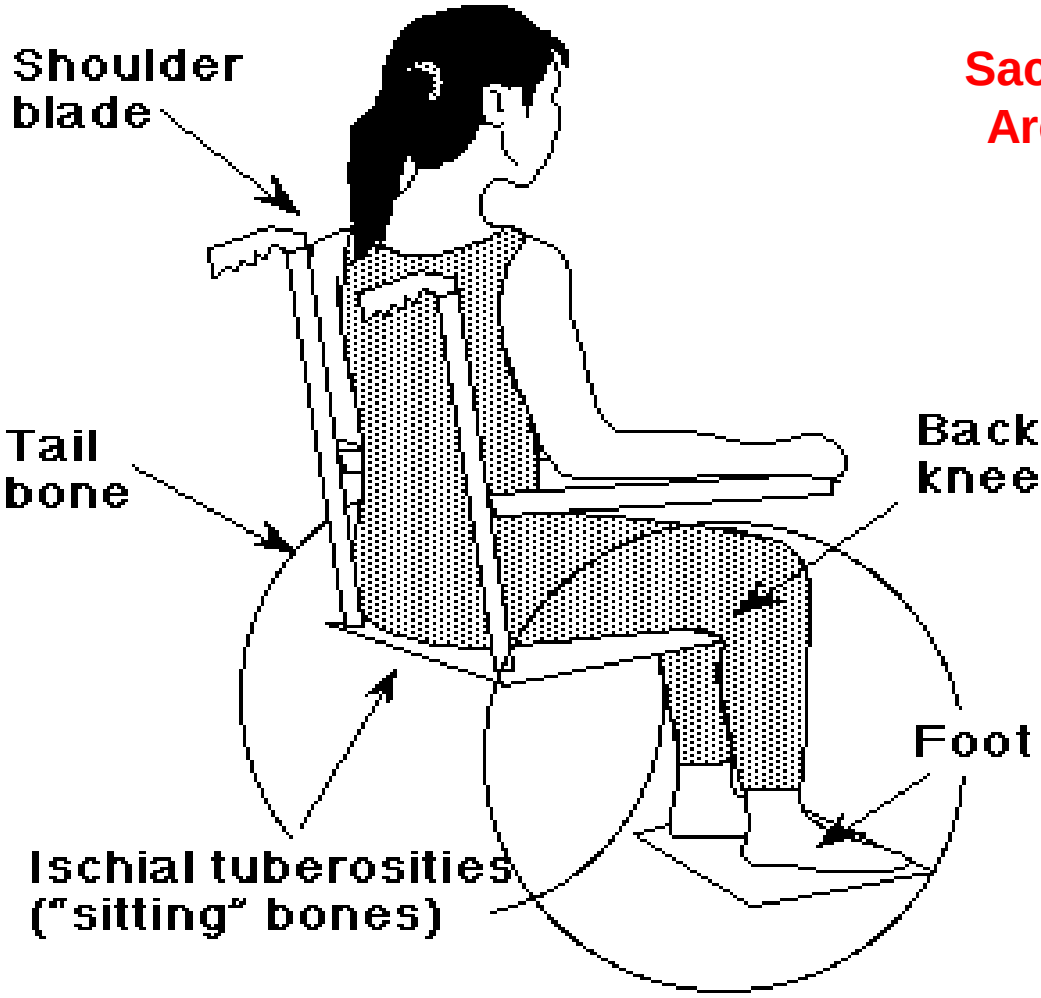
Knightime designs

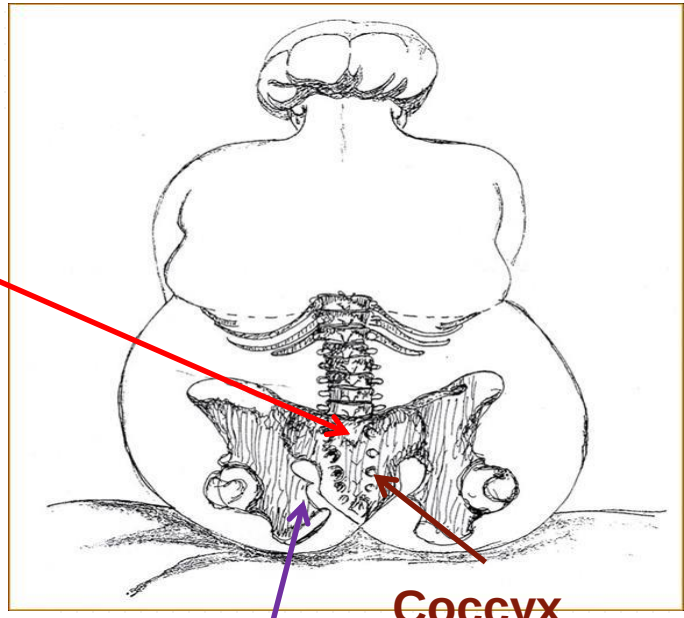
What is a Pressure Injury?

"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

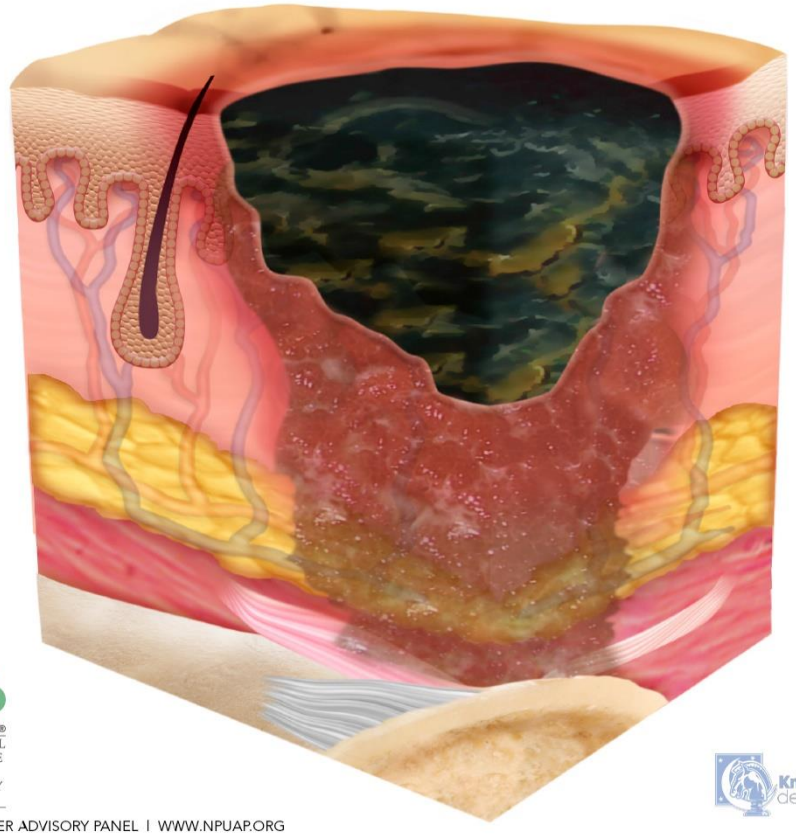




Transforming Lives

The Hospital & DSHS Experience

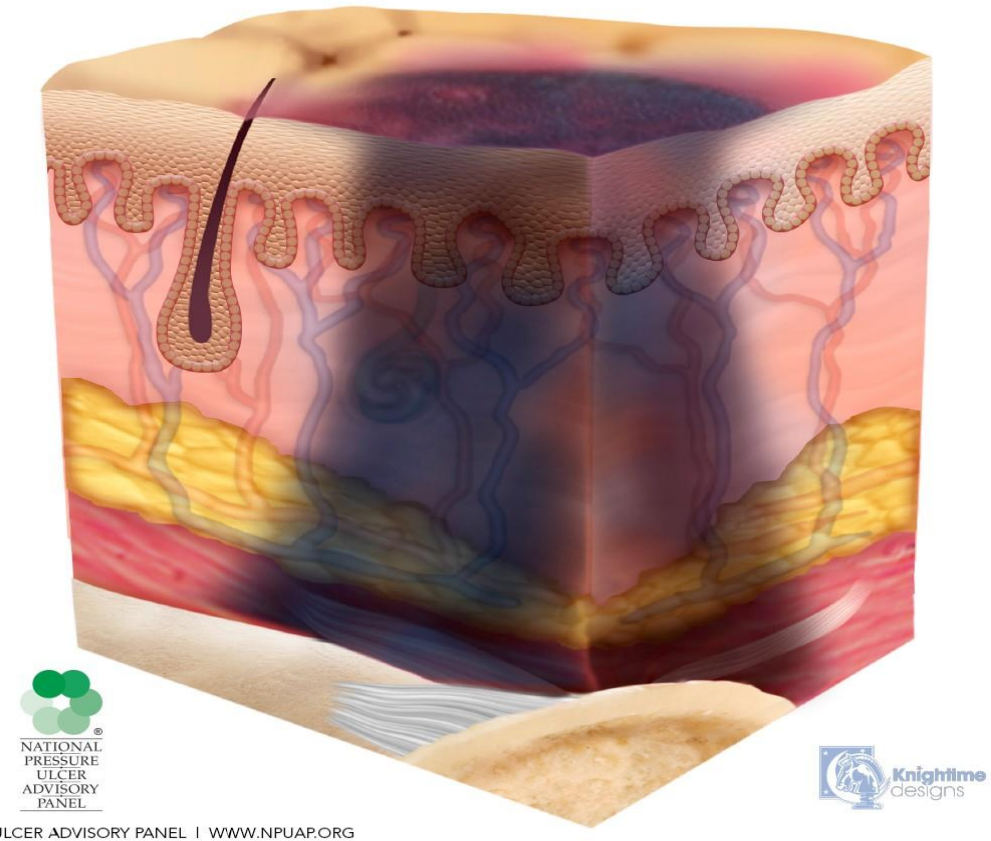
Unstageable Pressure Injury – Dark Eschar



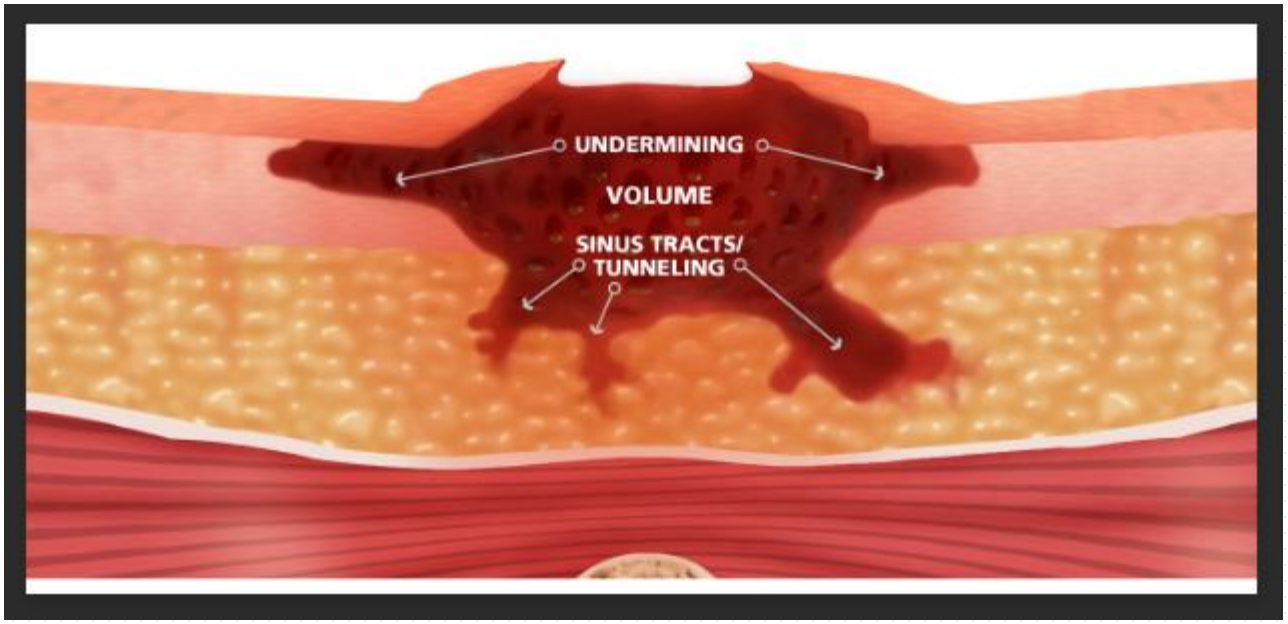
NATIONAL PRESSURE ULCER ADVISORY PANEL

Knightime designs

Deep Tissue Pressure Injury



Undermining/ Tunneling



6 months later...

Phase

Hospital

DSHS (HCS)

Area Agency on Aging

How will the hospital determine clients Medicaid Eligibility?

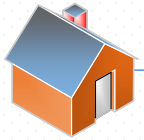
Hospital Stay 1-28 days

How is CM Identified of client hospitalization

Is the CM apart of Discharge Planning discussion

How & Who will introduce Nursing Service option to client ?

Hospital Discharge Team Meets to discuss next steps



Client at home
With caregiver

6 months later

Client is discharged back home
Family alerts CM of hosp. visit

AAA CM performs a Significant change
Introduces ADH option

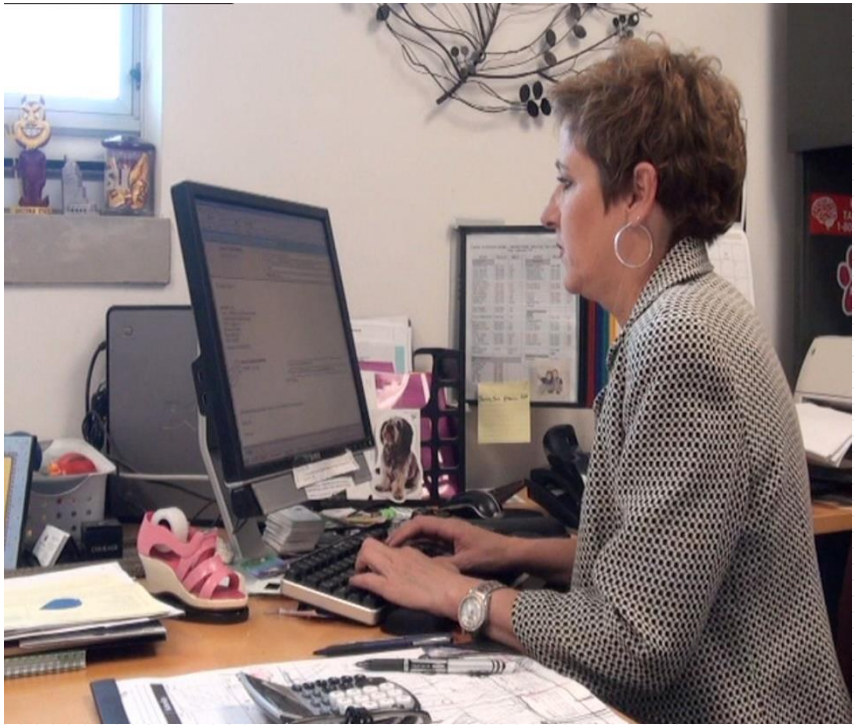
Client declines, Needs Met by Caregiver
No referral sent

Transforming Lives

Assessment

Comprehensive Assessment Reporting and Evaluation (CARE)

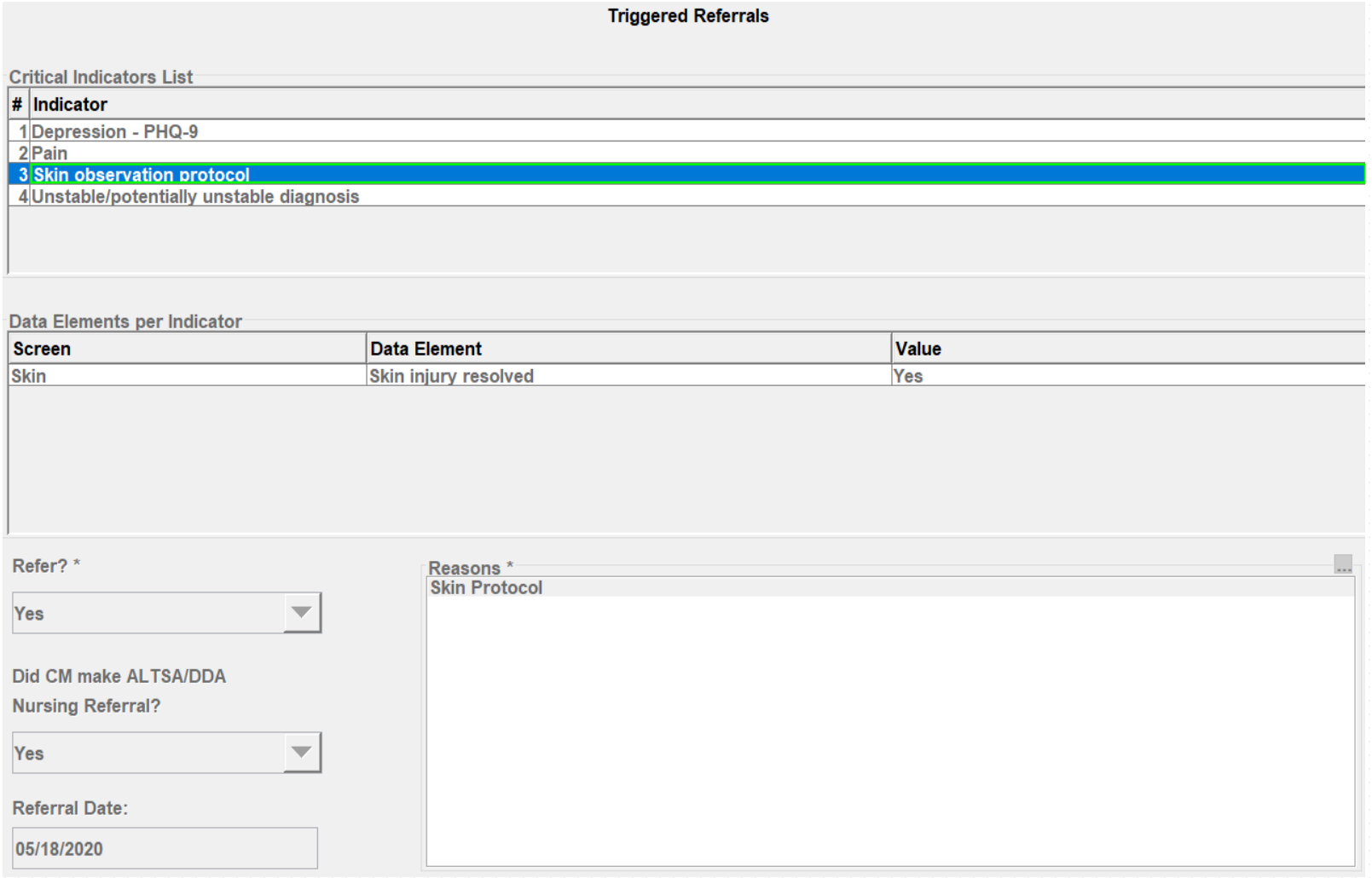
- Computerized client assessment
  - Triggers Nursing Referral Indicators
    - **Skin Observation Protocol (Mandatory Referral from CM)**



What are the Nursing Referral Triggers?

- 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**

Care Plan Triggered Referrals



SKIN OBSERVATION PROTOCOL & CASE MANAGER RESPONSIBILITIES

What will trigger the Skin Observation Protocol?

- Highest Risk Indicators
  - Current pressure injury
  - Quadriplegia
  - Paraplegia
  - Hemiplegia with cognition & incontinence issues
  - Total Dependence in Bed Mobility
  - Bedfast&/or Chairfast
    - Cognition problems
    - Bladder/Bowel

What are the Skin Observation Protocol Requirements?

HCS- Policy(LTC Chap 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.

DDA Policy 9.13

8. Notify the client or the client's legal representative that a skin observation protocol assessment was triggered, a referral to a nurse is being processed, and a nurse will contact them to schedule a visit. All visits must be in-person unless there is current documentation from the client's primary medical provider regarding the client's skin integrity.

CASE MANAGER RESPONSIBILITIES

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

Non-Licensed vs Licensed

Non-Professional	Professional (HCP)
HCA Certified	Physician
Individual Provider	Wound Care Clinic
Agency Home Care Worker	ARNP, PA-C, RN or LPN
Residential Caregiver	Home Health Nurse
Family Member	Physical Therapist
Informal Caregivers/support	

CASE MANAGERS RESPONSIBILITIES

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

- **DDA Clients –** Case Resource Managers will follow SOP Referral Tree
  - *Nurse Delegators may receive a referral if there is not a AAA willing to do the assessment(Applicable to Region 1)*

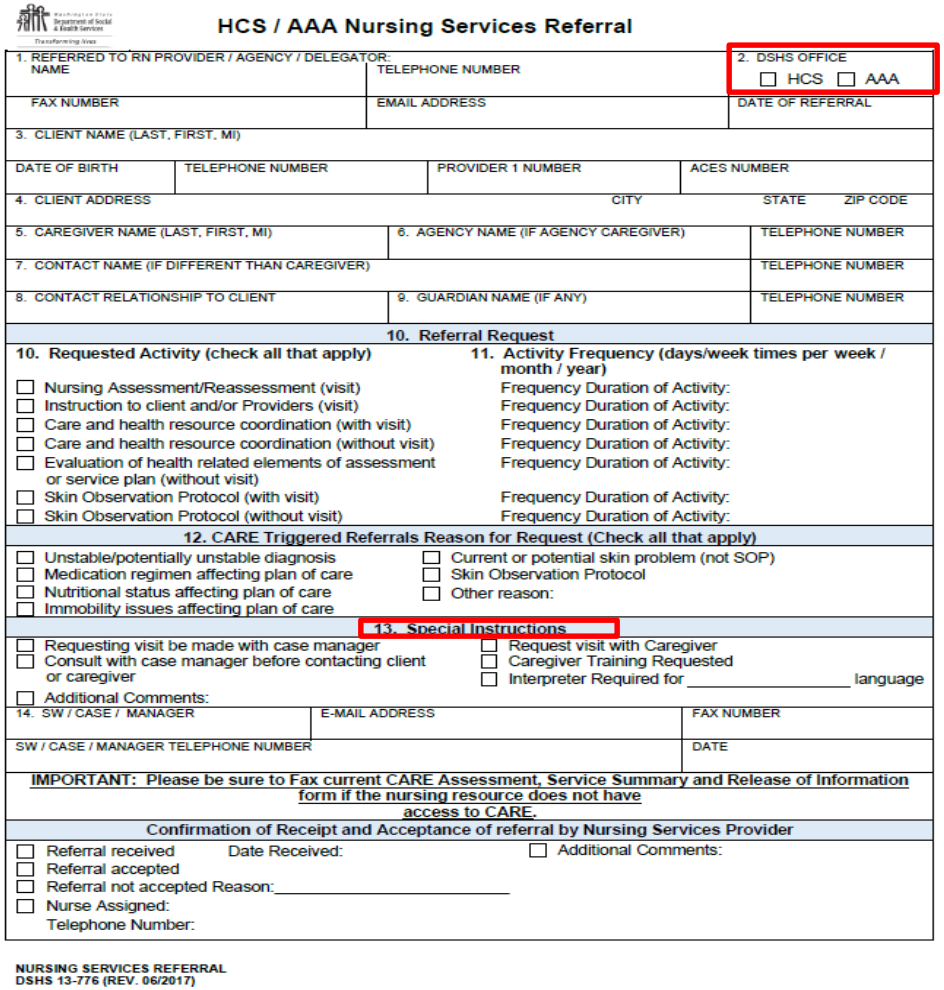
Referral Forms & Timeframes

From Case Manager to Nurse Delegator

SOP REFERRAL FORM

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:

NURSING SERVICES REFERRAL
DSHS 13-776 (REV. 06/2017)

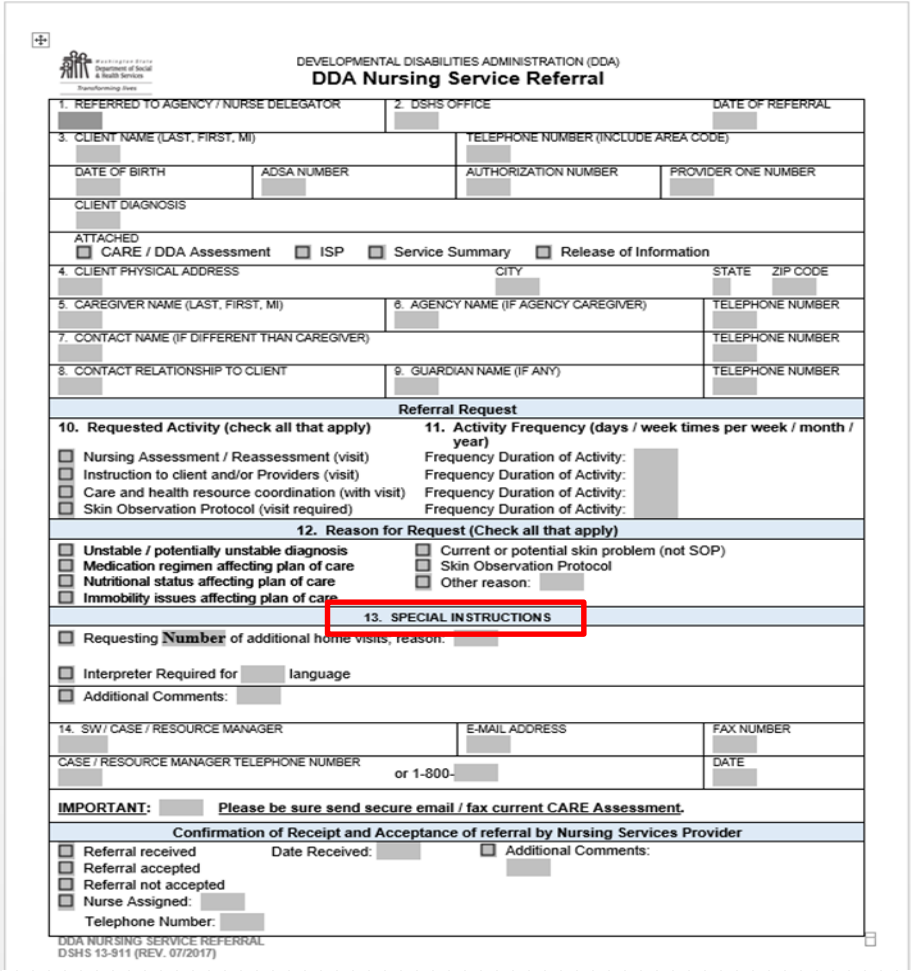
HCS# 13-776

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
☐ Additional Comments:	☐ Interpreter Required for _____ language

SOP REFERRAL FORM

DDA # 13-911

- 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



DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

DDA Nursing Service Referral

1. REFERRED TO AGENCY / NURSE DELEGATOR | 2. DSHS OFFICE | DATE OF REFERRAL

3. CLIENT NAME (LAST, FIRST, MI) | TELEPHONE NUMBER (INCLUDE AREA CODE)

DATE OF BIRTH | ADSA NUMBER | AUTHORIZATION NUMBER | PROVIDER ONE NUMBER

CLIENT DIAGNOSIS

ATTACHED
☐ CARE / DDA Assessment ☐ ISP ☐ Service Summary ☐ Release of Information

4. CLIENT PHYSICAL 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

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:
☐ Skin Observation Protocol (visit required) — Frequency Duration of Activity:

12. Reason for Request (Check all that apply)

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

13. SPECIAL INSTRUCTIONS

☐ Requesting Number of additional home visits, reason:

☐ Interpreter Required for language

☐ Additional Comments:

14. SW / CASE / RESOURCE MANAGER | E-MAIL ADDRESS | FAX NUMBER

CASE / RESOURCE MANAGER TELEPHONE NUMBER or 1-800- | DATE

IMPORTANT: Please be sure send secure email / fax current CARE Assessment.

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

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

DDA NURSING SERVICE REFERRAL
DSHS 13-911 (REV. 07/2017)

DDA #13-911

13. SPECIAL INSTRUCTIONS
☐ Requesting Number of additional home visits; reason:
☐ Interpreter Required for language
☐ Additional Comments:

Example HCS 13-776

Washington State Department of Social & Health Services
Transforming lives

HCS / AAA Nursing Services Referral

1. REFERRED TO RN PROVIDER / AGENCY / DELEGATOR: NAME: All Star Nurse Delegation	TELEPHONE NUMBER: 253-123-4567		2. DSHS OFFICE ☒ HCS ☐ AAA
FAX NUMBER: 253-765-4321	EMAIL ADDRESS: allstarnd@netscape.com		DATE OF REFERRAL: 12/02/2020
3. CLIENT NAME (LAST, FIRST, MI): Grandma, Charlie Mae			
DATE OF BIRTH: 01/05/1911	TELEPHONE NUMBER: 253-098-7654	PROVIDER 1 NUMBER: P1xxxxxxxxx	ACES NUMBER: xxxxxxxxxxx
4. CLIENT ADDRESS: 1 Elder Watson Diggs Ave	CITY: Pleasantville	STATE: WA	ZIP CODE: 98111
5. CAREGIVER NAME (LAST, FIRST, MI): Sallie, Mae	6. AGENCY NAME (IF AGENCY CAREGIVER): Freddie Mac		TELEPHONE NUMBER: 253-456-7890
7. CONTACT NAME (IF DIFFERENT THAN CAREGIVER)			TELEPHONE NUMBER
8. CONTACT RELATIONSHIP TO CLIENT	9. GUARDIAN NAME (IF ANY)		TELEPHONE NUMBER

HCS 13-776

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: **2days/week**
☐ 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 (SOP)
☒ 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
Jerome Spearman	**spear@dshs.wa.gov**	
SW / CASE / MANAGER TELEPHONE NUMBER		DATE
253-000-1111		**12/02/2020**

IMPORTANT: Be sure to send, via fax/secure email a current CARE Assessment Details, Service Summary, Release of Information, and a copy of all of the Nursing Triggered Referrals including the Data Elements.
Note: If you are serving a DDA client please use DSHS form 13-911.

HCS 13-776

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

- [x] Referral received Date Received:
- [x] Referral accepted
- [ ] Referral not accepted Reason:_____
- [x] Nurse Assigned: **Nurse Betty**

  Telephone Number: **253-111-2222**

- [ ] Additional Comments:

NURSE DELEGATORS RESPONSIBILITY

- Accept referral—time frame (DDA-HCS)

HCS	DDA
CM SEND REFERRAL FORM IN 2 BUSINESS DAYS	CM SEND REFERRAL FORM IN 2 BUSINESS DAYS
48 HOURS RESPOND TO REFERRAL	RND HAS 1 DAY TO ACCEPT AND 2 DAYS SCHEDULE VISIT
5 DAYS RETURN DOCUMENTATION TO CASE MANAGER	5 DAYS RETURN DOCUMENTATION TO CASE MANAGER

RESOURCES

Prevention Plans

Pictures

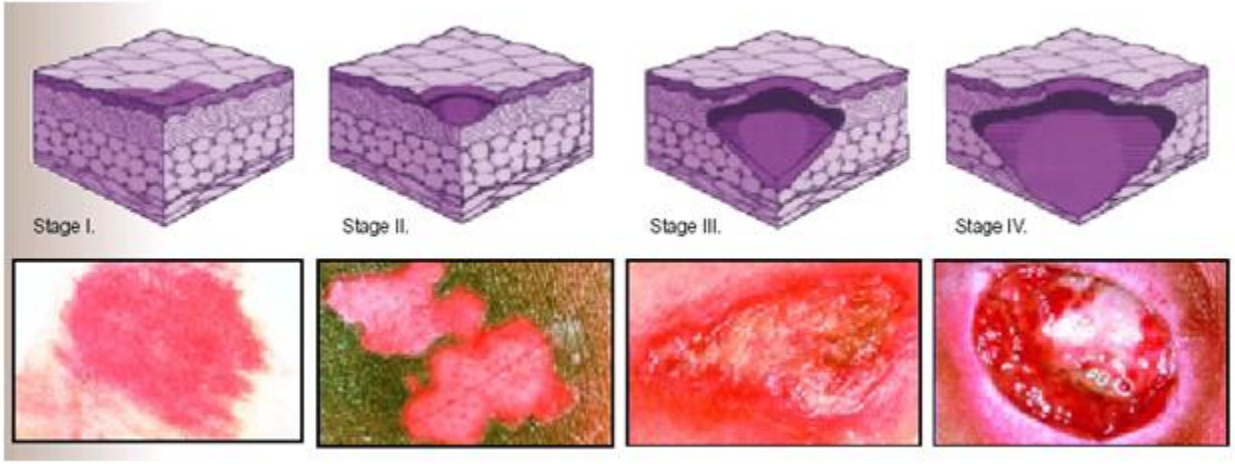
Resources

https://www.dshs.wa.gov/altsa/home-and-community-services/nursing-services

Documents

- Patient Education - University of Washington
- Skin Care and Pressure Sores (PDF)
  - Part 1: Causes and Risks
  - Part 2: Prevention
  - Part 3: Recognizing and Treating
- Pain After Spinal Cord Injury (PDF)
- Staying Healthy After a Spinal Cord Injury (PDF)
  - Bladder Management
  - Taking Care of Your Bowels: Ensuring Success
- DDA SOP Referral Letter
- Glossary of Terms
- Photographs and Descriptions of Pressure Ulcers
  - Translated Versions
- Prevention Plan for Skin Breakdown Over Pressure Points
  - Translated Versions
- Skin and Body Care
- Skin Observation Protocol Assumptions
- Skin Observation Protocol Frequently Asked Questions
- Skin Observation Protocol Sample Documentation
- Skin Observation Protocol Flowchart
- Basic Training for Nurse Delegator Responsibilities for Skin Observation Protocol (PowerPoint)
- Skin Observation Protocol Basic Skin Assessment Form
- Skin Observation Protocol Pressure Inquiry Assessment Form
- Skin Observation Prevention Plan
- Skin Observation Protocol Healthy Skin 1
- Skin Observation Protocol Healthy Skin 2

Pictures



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

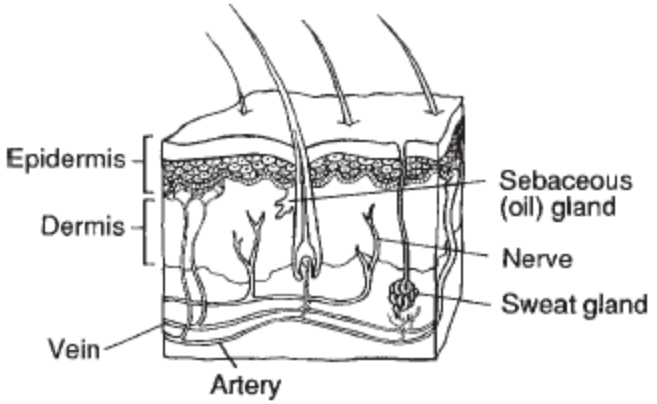
Northwest Regional SCI System

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.



SOP SCENARIOS &
NURSE DELEGATOR RESPONSIBILITIES

What are the Skin Observation Protocol Requirements?

HCS- Policy(LTC Chap 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.

DDA Policy 9.13

8. Notify the client or the client's legal representative that a skin observation protocol assessment was triggered, a referral to a nurse is being processed, and a nurse will contact them to schedule a visit. All visits must be in-person unless there is current documentation from the client's primary medical provider regarding the client's skin integrity.

Observation Not Required

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 or 13-911
- Complete 13-780

Scenario 1

1. A non-professional is providing skin care (treatment) for a client who has a pressure ulcer. The HCS/AAA/DDA social worker must refer the same day as the assessment. On the same day as the assessment (when possible), but not to exceed two working days, the HCS/AAA/DDA nurse or other contracted nursing resource must:
    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 nursing note.

Scenario 1
Sample Documentation

The client and/or caregiver contacted [name] on [date/time] for **review** of treatment being provided to pressure ulcer(s) located at [location(s) of ulcer(s)]. The **treatment plan** includes:

[Ulcer location], [description of treatment]
[Ulcer location], [description of treatment]
[Ulcer location], [description of treatment]
(repeated as needed for each pressure ulcer)

The pressure ulcer treatment was **authorized by** [HCP name(s)].

Verify with [caregiver name] that he/she is observing all pressure points. The caregiver is observing all pressure points [insert the frequency or times when pressure points are being observed].

Educational materials provided to the client and/or caregiver included: [list all materials that were provided and/or reviewed], for example: 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).

The care plan (was /was not) **revised** to include the following care needs [insert suggested revisions to care plan].

Nursing Documentation must be sent back to CM to be uploaded into CARE

Scenario 2

2. **A professional is providing skin care (treatment)** for a client who has a pressure ulcer. The HCS/AAA/DDA Social Worker/Nurse or other contracted nursing resource must:
   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 ulcers. At that time, consult with Nursing Services resources;
      iii. Document all activities in nursing note.

Scenario 2
Sample Documentation

Verify with [Health Care Provider Name (HCP)] by (phone/fax/email) 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 ulcers are [insert healing, not healing, granulating, etc.] and the treatment will be (continued/discontinued/re-evaluated) on [date].

The HCP (is/is not) observing all pressure points.

Request notification from [HCP name] when the client is discharged from service for treatment to pressure ulcer(s) so that consultation with Nursing Services regarding any ongoing care needs to pressure ulcer(s) or skin may occur.

Scenario 3

3. **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.** The HCS/AAA/DDA social worker/nurse or other contracted nursing resource must:
   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 your nursing note;
   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 your nursing note.

Scenario 3 Documentation

Verify with [caregiver name] that he/she is observing all pressure points. The caregiver is observing all pressure points [insert frequency or times when pressure points are being observed].

Verify 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 ulcers** and (confirmed/denied) 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 (was/was not) **revised** to include the following care needs: [insert suggested revisions to the care plan].

Scenario 4

4. **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:**

   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:
      1Refer to the HCS/AAA/DDA nurse or other contracting nursing resources for follow up; or
   e. Contact the client's primary care provider as soon as possible, discuss skin concerns and document; or
   f. Advise the client of skin care issues, educate and document; and

Do not complete skin observation.

Document that the client has declined skin observation

Scenario 4
Sample Documentation

- Document that the client declined observation
- Document reasons for declination
- Any relevant information from conversation
- If able to secure observation, follow Observation Required Steps.

Observation Required

Scenario 5

Observation is required when the client meets highest risk indicators and no one (neither a professional nor non-professional) is providing skin care that has been documented and verified as meeting the client's needs as above in (1) (2) and (3), or all pressure points are not being observed.

In this case:

1. Refer the client to the HCS/AAA/DDA nurse or other contracting nursing resources to complete the observation.
2. Arrange to have a third party present if you know in advance that there is a likelihood that you will need to observe the client's skin, or as requested by the client.
3. Involve the client in determining who this third party should be, when possible. Parental, guardian or client representative consent must be obtained for those individuals with designated decision makers.
4. Explain what is involved in the skin observation to the client and obtain the client's permission.
5. Tell the client where the pressure points are.
6. Help or have the caregiver help if the client needs to undress partially. Be sure that there is privacy for the client and the client remains covered except for the area being observed
7. Look at the back of the head, ears, shoulder blades, elbows, insides of the knees, "seat" bones, tailbone area, hips, sides of ankles and both heels.
8. Observe for specific conditions - skin intact, persistent redness, abrasion, blister, shallow crater, deep crater, etc., as directed in the CARE assessment using the skin problem screen and skin observation descriptions as a guide. (See the OBSERVATION REQUIRED section of the Sample Documentation for additional information.)
9. If **no** skin problem is observed, document the prevention plan(s) as appropriate.
10. If **a skin problem is observed**:
    a. Determine if there are any health professionals involved with treatment of the client's skin problem or if any health professionals are aware of the problem;
    b. Contact any health professionals involved with treatment of the client's skin problem, within 2 working days, or contact the family

Scenario 5

representative if no health professionals are involved, the client is refusing treatment, or the health professional is not treating;

c. Document all observations and all activities provided in the Service Episode Record or progress note. (See the OBSERVATION REQUIRED section of the Sample Documentation for additional information.);

d. The HCS/AAA/DDA SW/CM must follow up with any RN recommendations.

Scenario 5
Sample Documentation

Referral received from [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).

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 tuberosity's, hips, ankles (medial and lateral) and heels).

Observed the following skin changes [insert description of any areas with changes]

1. Any noted skin changes with locations (basic skin assessment):
    a. Temperature
    b. Color
    c. Moisture
    d. Turgor
    e. Integrity
    f. Nails
    g. Hair
    h. Moles
    i. Injury

2. Pressure points observed [insert any alterations from intact].

3. Pressure ulcers observed
    a. The documentation for each pressure ulcer observed should include the following detail:
        i. Location
        ii. Classification

Scenario 5
Sample Documentation

iii. Measurement
iv. Wound pain
v. Wound exudate – amount and character
vi. Surrounding skin
vii. Tunneling
viii. Undermining
ix. Wound bed
x. Additional descriptions/comments

Scenario 5
Sample Documentation

If a skin problem is observed:

Contact made by (phone/fax/email) 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 any prevention plans].

If no skin problem is observed:

Contact made by (phone/fax/email) with [list contact names and relationship to the client] to discuss finding of Skin Observation visit and [insert 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) **revised** to include the following care needs: [insert suggested revisions to care plan including any prevention plans].

Form 13-780

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

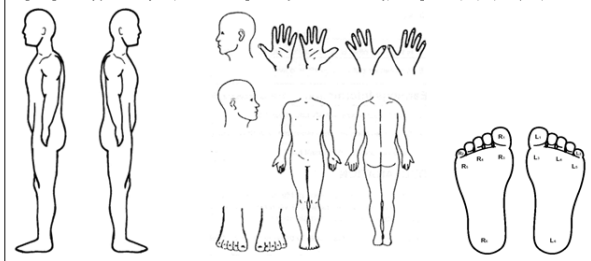
REQUEST RELATED TO **(REQUESTOR COMPLETES)**: CHECK ALL THAT APPLY

- ☐ 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.)

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**

Form 13-783

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

Observation Delayed

Observation Delayed

1. It is unsafe (e.g. threatening animals, sexually inappropriate behavior or threatening behaviors);
2. It is unsanitary (because of soiling or unhygienic conditions) and no caregiver is present to assist;
3. It is difficult to observe because of the client's physical condition (immobile, needs transfer or positioning assistance, client is in pain);
4. It is impossible to observe because the client refuses to allow observation, has an unreliable provider and won't let anyone else in, and /or refuses services related to skin integrity over pressure points.
5. The client is cognitively intact, declines skin observation over pressure points, and there is evidence of negative skin outcome (foul odor, staining on clothing over pressure points or other visible sign). Determine and provide any or all of the following activities appropriate to the client situation:

    a. Refer immediately to the nurse or Nursing Services resources for an observation visit as soon as possible, if HCS/DDA Social Worker or AAA Case Manager is not a nurse;

Questions?