Skin Observation Protocol for Delegating Nurses

Doris Barret Kay Sievers Anne Vander Beek Nurse Delegation Program Managers

Purpose of the Training

o Part I

- Introduce the protocol
- Establish observation and documentation standards
- Explain the role of CM in referring to RND
- Explain the role of RND in implementing

Purpose of the Training

o Part II

- Provide standardized forms for feedback to case manager (CM)
- Provide references and resources for observation and reporting



Skin Observation Protocol Part I -- Why do we have it?

- Identifies clients at high risk for pressure ulcers
- Helps DSHS case managers (CM) determine when a nursing assessment of client's skin is necessary
- Describes what should be done, who should do it, and how interventions should be documented

Skin Observation Protocol *What is it?*

- Series of actions to take when a client is at highest risk for skin breakdown due to pressure
- Client's risk is identified through the CARE assessment
- The actions are mandatory and must be completed

The CARE system is

- ADSA's computerized client assessment
- Only accessed by the Case Manager or other members of ADSA staff
- Programmed to trigger the Skin
 Observation Protocol when a client's
 assessment places them in high risk
 category for skin breakdown

Documenting pressure ulcers outside the CARE tool

- Since delegating nurses do not have access to CARE, two forms are provided for getting the needed feedback to the Case Manager
- o CM will then document in CARE

Skin Observation Protocol *Basic Assumptions*

 The Protocol is mandatory and must be completed for each client whose needs trigger a high risk indicator

All activities must be provided and documented

Highest risk indicators Stand alone elements

If client has one of these, he/she is at highest risk

- o Current Pressure Ulcer
- o Quadriplegia or paraplegia
- Total dependence in bed mobility
- Comatose or persistent vegetative state
- History of pressure ulcer within the past year

Highest risk indicators Combination elements

If a client has the combination listed, he/she is at highest risk.

- Bedfast or chairfast and cognition problems
- o Bedfast or chairfast and incontinence
- Hemiplegia, cognition problems and incontinence
- Bedfast or chairfast and IDDM

Skin Observation Protocol To see or not to see—that is the question

The protocol determines whether an observation visit is needed based on:

- Whether the client has a known pressure ulcer; and
- Whether there is a professional caregiver involved and
- Whether there is adequate treatment in place; and
- The cognition of the client.

Who is a professional/nonprofessional caregiver

- Professional
 - RN or LPN
 - Physical Therapist
 - Wound care clinic
 - Physician
 - ARNP
 - PA-C



Non-Professional

- Individual Provider
- Agency home care worker
- Family member
- Other informal caregivers/support

Skin Observation Protocol Case Manager Responsibilities

Case managers are expected to

- Gather indicator information
- Identify when the SO protocol is triggered
- Document in CARE; and
- Make appropriate referrals according to the protocol

Skin Observation Protocol Case Manager Responsibilities

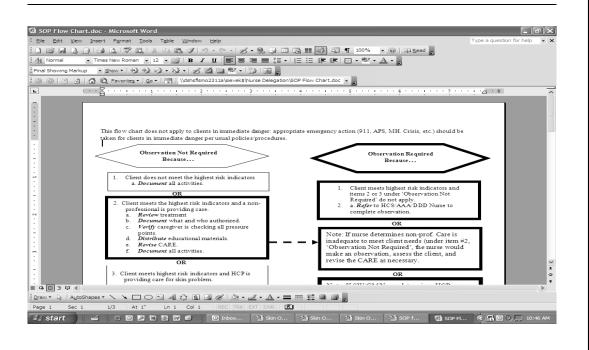
Case managers will communicate with

- Nurse Delegator if a client is actively receiving delegated task(s)
- Nurse Delegator if assessment triggers the Skin Observation Protocol
- IP to determine if IP is currently checking pressure points
- Home care agency to determine if agency worker is currently checking pressure points

Skin Observation Protocol Case Manager Responsibilities

- Flow Chart indicates when a nurse (the RND) must be involved and whether or not the nurse must visit and assess the client
- To review entire Flow Chart, see additional information listed on the website

Skin Observation Protocol Flow Chart



The Skin Observation Protocol

- The SO Protocol flow chart does not apply to clients in immediate danger
- When a client is in immediate danger, appropriate emergency actions should be taken (911, APS, MH Crisis intervention)
- Nothing in the protocol prevents a nonnurse from observing a client's skin and describing findings as long as nurse involvement occurs when needed.

Skin Observation Protocol--Scenarios

The following Scenarios describe

- When a nurse (the RND) must be involved
- o When a visit is required, and
- What is expected of the RND
- Scenarios 1, 2 and 4 do <u>not</u> require RN
- Scenarios 3,5 <u>do</u> require RN involvement

Observation NOT required

No nurse action required/nurse may consult

CM may not need to refer to RND when

Scenario 1

- Non-professional provides care
- All pressure points checked within last 7 days
- o No skin problems apparent
- o CM documents in CARE

Observation NOT required
No nurse action required/nurse may
consult

CM may not need to refer to RND when Scenario 2

- Non-professional caregiver is not checking all pressure points
- Client is cognitively intact
- o Client refuses to allow observation
- o It is **not known** if a pressure ulcer exists
- o CM has additional follow up responsibilities

Observation NOT required Action by a nurse IS required

CM must refer to RND when Scenario 3 (#2 on SOP Flow Sheet)



- Non-professional is providing care
- o Client has a skin problem over a pressure point
- CM refers on the same day as client assessed
- On date of referral or not to exceed two working days, the delegating nurse will
 - Inform CM if unable to meet time frames
 - Review current treatment
 - Document current treatment and who authorized

Observation NOT required Action by a nurse IS REQUIRED (cont)

RND responsibilities <u>Scenario</u> 3 (#2 on SOP Flow Sheet)

- Verify cg is checking all pressure points
- Distribute additional educational materials as needed
- Forward documentation of all activities to CM
- CM will revise CARE assessment
- Nurse may visit if need to determine whether non-professional care is adequate

Observation NOT required No nurse action required



Scenario 4 (#3 on SOP Flow Sheet)

professional is providing care
Skin problem is over a pressure point
Case Manager shall:

- Verify treatment plan in place
- Verify skin has been seen by the HCP (within last 7 days)
- Verify with HCP that all pressure points being checked (< 5 working days)

Observation NOT required No nurse action required/may visit

Scenario 4 (#3 on SOP Flow Sheet)

Case Manager shall:

 Request notification when client is d/c from HCP for pressure ulcer care

RND Responsibilities

- Nurse may visit if HCP does not have a treatment plan in place and/or has not been observed all pressure points
- Document all activities
- Forward documentation of all activities to CM
- CM will revise CARE assessment.

Nursing Observation REQUIRED

Scenario 5

Neither non-professional nor professional are providing any specific skin care or treatment to the client; or

No one is providing care to the client; or The care that is being provided is inadequate; or

The pressure points are not being observed

o More on the next slide ...

Nursing Observation REQUIRED

Scenario 5 (continued)

RND responsibilities

- Explain to the client what is involved in an observation
- Arrange to have a third party present if needed
- o Help or have the cg help the client undress
- Look at the pressure points

Nursing Observation REQUIRED

Scenario 5 (continued)

RND responsibilities

- Observe for specific skin changes or conditions
- o Document as directed on the (name of form)
- Communicate findings to client's CM for inclusion in CARE

Skin Observation Protocol

In all scenarios—RND Responsibilities

If no skin problem is observed

- o Communicate with client's case manager
- Document findings including teaching caregivers a Prevention Plan*
- o CM will revise CARE to include *Prevention Plan* as appropriate.

* To review entire *Prevention Plan*, see additional information listed on the website

Skin Observation Protocol

In all scenarios—RND Responsibilities

If a skin problem is observed

- Determine if a HCP is treating the client's sking problem
- Contact HCP within 2 working days for orders
- Contact client's family rep if no HCP, if client is refusing treatment or if HCP is not treating
- Communicate with client's case manager
- Document findings
- CM will revise CARE to include your documentation as appropriate

Skin observation may be delayed when

- Unsafe situation or inappropriate behaviors
- Immobility of the client does not allow observation
- Client refuses observation
- Unsanitary conditions make it impossible to examine the client
- Client is cognitively impaired and declines skin observation

What to do when observation is delayed—RND Responsibilities

Provide any of the following activities:

- Discuss immediately with referring case manager
- Try to reschedule visit within 2 working days
- Refer to APS, CRU, 911, health care provider/resources as appropriate

What to do when observation is delayed--RND (continued)

Provide any of the following activities:

- Educate caregiver
- Document, document, document detail of the interaction
- Submit your documentation to CM ASAP!

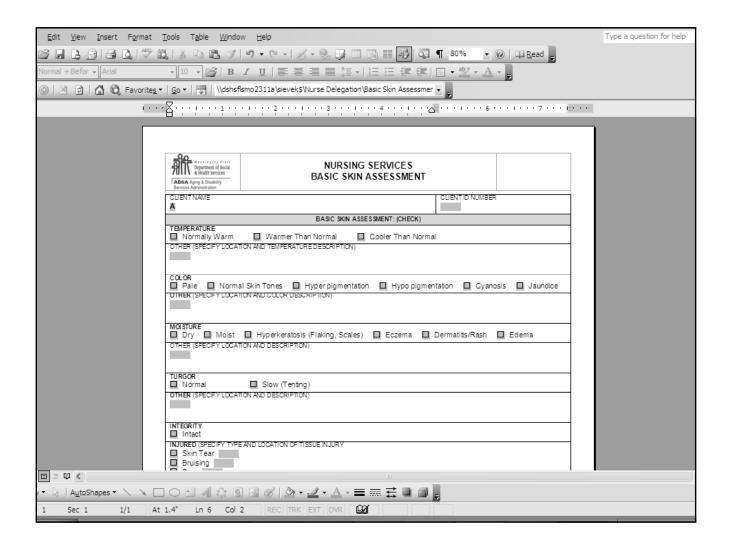
Documenting Skin Assessments— RND Responsibilities

- Skin assessments of either kind are part of the nurse delegation paperwork, and copies should be left in the client chart and retained in your own personal nurse delegation files.
- In addition, a copy should be forwarded to the Case Manager for documentation of follow up on the protocol.

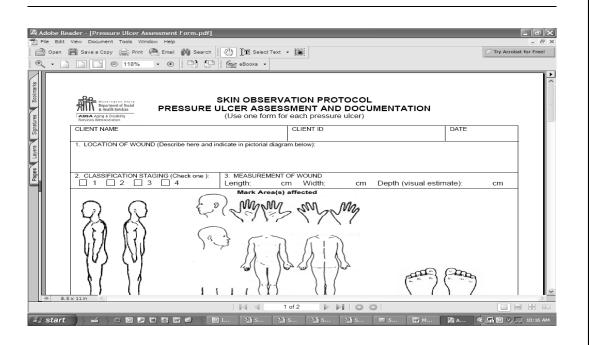
Two forms available--RND

- o Basic Skin Assessment form
- Pressure Ulcer Assessment and Documentation form





Pressure Ulcer Assessment form



Two forms available—Basic Skin Assessment, Pressure Ulcer Assessment

- Neither form is mandatory, but the content of each is required. This will inform the CM of the status of the client and required follow up and recommendations.
- See additional information listed on the website for printable versions of both forms for your use.

Skin Observation Protocol

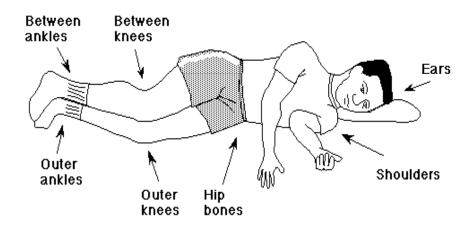
o Part II

- References and resources for observation and reporting
- Standardized forms for RND feedback to case manager (CM)

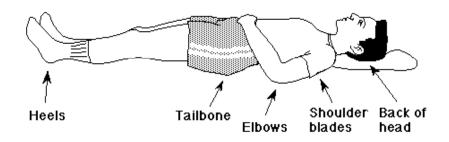
What is a pressure point

- Pressure points are the areas of the body where skin and tissue are squeezed between the bone and an outside surface.
- Bony parts of the body may press against other body parts, a mattress or a chair.
- The constant pressure closes off tiny blood vessels, the tissue dies and a pressure ulcer forms.

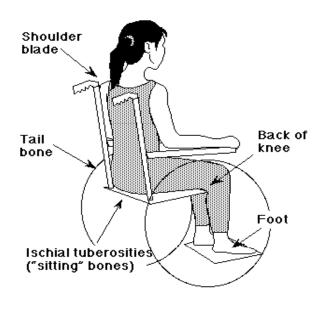
Bony prominence locations

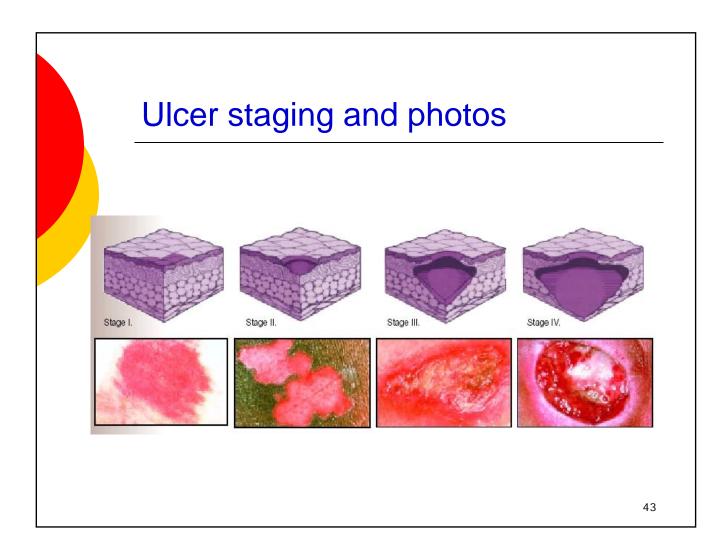


Bony Prominence Locations



Bony Prominence Locations





Pressure Ulcer with Eschar

- When eschar (a scab) is covering an ulcer it cannot be staged
- Follow the SO protocol and refer the client to their health care provider for consultation/observation visit



Other skin breakdown/non-pressure etiology

- There are a variety of reasons that can cause skin breakdown other than pressure over boney prominences:
 - These other reasons are built into the CARE assessment and the Nursing Referral Algorithm; they include:
 - Abrasions, skin tears, burns, lesions, rashes, skin fold and perineal rashes, surgical wounds, venous, arterial, and neuropathic ulcers

How to tell the difference and what to do

- The Skin Observation protocol will trigger those clients at highest risk for skin breakdown due to pressure;
- The Nursing Services algorithm will trigger those clients at highest risk for skin breakdown due to other causes.
- Follow the SO protocol when triggered and follow the NS referral triggers as assessed.
- The RN should be consulted for the differentiation and additional assessment needs.

Some examples of other skin breakdown

o Venous leg ulcer



Other skin breakdown

Diabetic Foot Ulcer



Other skin breakdown

Arterial Ulcers (usually ankles, feet)



Figure 3. Arterial ulcers developed over dorsum of the right foot in a 76year-old woman with hypertension. The ulcers were most likely precipitated by shoe abrasion.

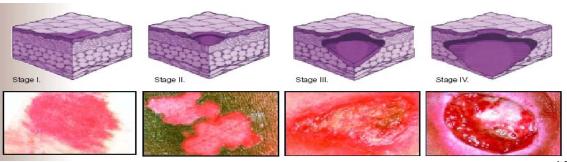
Other skin breakdown

 Perineal area--Raised or flat, red diffuse rash found in the perineal area or under and along skin folds. Client can have drainage and odor, as well as complaints of burning pain or itching.



Skin Observation Protocol Staging a Wound

- Use the color pictures included with the protocol as a resource
- Document all activities and communicate findings to client's CM
- CM will revise information in CARE



Skin Observation Protocol Staging a Wound

- Stage I Area of persistent skin redness
- Stage II- Partial loss of skin layers
- Stage III Full thickness skin loss
- Stage IV Full thickness skin loss with extensive destruction of underlying tissue and structures
- The CARE tool combines Stage III and IV

Size (Ulcer surface and depth)

- Measure the greatest length (head to toe) and the greatest width (side to side) using a centimeter ruler.
- Depth can be measured using a finger or cotton tipped applicator and measuring the mark in cm.
- Depth may be estimated if sterile equipment is not available.

Exudate or Drainage

Estimate the amount on the dressing as:

None, light, moderate, or heavy.

Describe the color as:

 Serous (watery), purulent, sanguineous (bloody), or sero-sangunieous (watery,pale red/pink).

Describe any odor

Type of tissue in wound bed

- Granulation tissue = healthy beefy red
- Necrotic = dead and avascular (eschar)
- Slough = yellow to gray (devitalized connective tissue)
- Epithelial = pearly, pink tissue that resurfaces a wound.

Wound pain

- o 0 to 10
- McGill Pain Questionnaire
- Amy's pain assessment for clients with dementia (facial expressions, legs, arms, cry and consolability)

Surrounding Skin

- Assess for the following:
 - Erythema (redness and inflammation)
 - Edema
 - Induration (hardening of tissue from inflammation)
 - Crepitus (crackling)
 - Pain
 - Warmth

Tunneling and undermining

Tunneling

 A channel or path that can extend from a wound margin or surface in any direction.

Undermining

 Tissue destruction underlying intact skin along a wound margin.

Suggestion

 Use clock positions to indicate location of tunnel or undermining of the wound.

Skin Observation Protocol in CARE

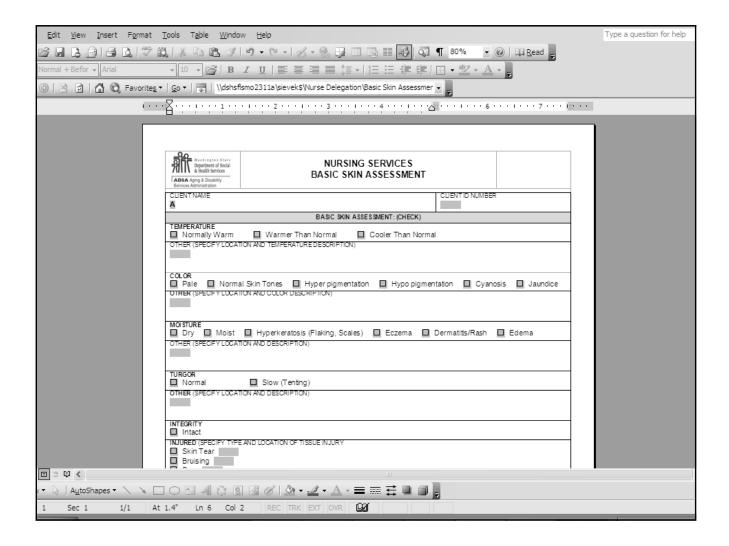
- The Skin Observation Protocol may be triggered by the CM assessing the client in the CARE system.
- The Skin Observation Protocol displays on the Nursing Referral Screen in CARE.
- The Skin Observation Protocol is not optional to follow – it is required for all clients in all care settings.

Skin Observation Protocol--Forms

- RND Responsibilities include documentation of the protocol and feedback to the Case Manager
- o Two forms may be used
 - Basic Skin Assessment form
 - Pressure Ulcer Assessment and Documentation form
- See additional information listed on the website for copies of each form

Basic Skin Assessment

- Nurse delegators use this form only for skin assessment when no pressure ulcer is found.
- The nurse delegator's usual assessment form may also be used if skin issues are addressed at the same level of detail as in the Basic Skin Assessment.



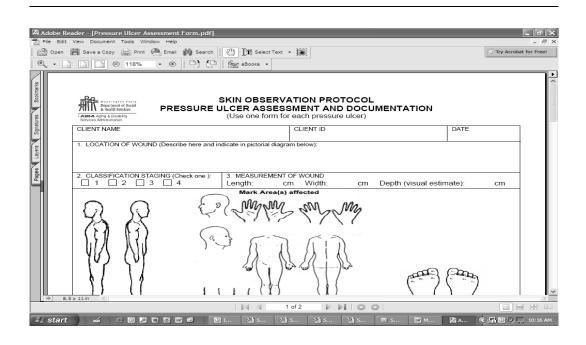
Pressure Ulcer Assessment

- Use this form to document the assessment of all pressure points when pressure ulcers are present.
- Use a separate form to document each pressure ulcer that is present.
- Additional pages may be added.

Pressure Ulcer Documentation

- Document and name all pressure points that were observed;
- Name any that were not observed, and why not;
- Document the status of problems observed over pressure points.

Pressure Ulcer Assessment form



Client/Caregiver Education Resources— Other Information Listed on the Website

- Fundamentals of Caregiving Module 7
 Skin and Body Care
- NW Regional SCI System (UW)
 - Maintaining Healthy Skin Part 1
 - Maintaining Healthy Skin Part 2
 - Taking Care of Pressure Sores
- o ADSA Pressure Point Prevention Plan

For More Information

Anne Vanderbeek 360/725-2558

vandea@dshs.wa.gov

Doris Barret 360/725-2553

barreda@dshs.wa.gov

Kay Sievers 360/651-6828

sievek@dshs.wa.gov