SKIN OBSERVATION PROTOCOL FLOW CHART

This flow chart does not apply to clients in immediate danger: appropriate emergency action (911, APS, MH. Crisis, etc.) should be taken for clients in immediate danger per usual policies/procedures.

Observation Not Required Because…

1. Client does not meet the highest risk indicators
   a. Document all activities.

OR

2. Client meets the highest risk indicators and a non-professional is providing care.
   a. Review treatment
   c. Verify caregiver is checking all pressure points.
   d. Distribute educational materials.
   e. Revise CARE.
   f. Document all activities.

OR

3. Client meets highest risk indicators and HCP is providing care for skin problem.
   a. Verify treatment plan in place and that skin has been seen by HCP.
   b. Communicate with HCP to verify all pressure points are being checked.
   c. Request notification when client is discharged from pressure ulcer care.
   d. Document all activities.

OR

4. Client meets highest risk indicators, prevention plan is in place, caregiver is checking all pressure points, and there is no reported skin problem.
   a. Verify that the caregiver is checking all of the pressure points.
   b. Verify that the prevention plan is meeting the client’s needs.
   c. Document what is being done as a prevention plan.
   d. Use the color pictures included with the protocol as a resource.
   e. Revise the care plan as needed.
   f. Document all activities.

OR

5. Client is cognitively intact, meets highest risk indicators, caregiver is not checking all pressure points, client declines observation and it is unknown if there is a problem.
   a. Probe for reasons.
   b. Suggest alternatives.
   c. Refer to nurse for follow-up.
   d. Contact HCP or advise client.
   e. Document all activities.

Observation Required Because…

1. Client meets highest risk indicators and items 2 or 3 under ‘Observation Not Required’ do not apply.
2. a. Refer to HCS/AAA/DDD Nurse to complete observation.

OR

Note: If nurse determines non-prof. Care is inadequate to meet client needs (under item #2, ‘Observation Not Required’, the nurse would make an observation, assess the client, and revise the CARE as necessary.

OR

Note: If SW/CM/Nurse determines HCP or caregiver does not have Treatment plan in place and/or has not been observing pressure points as part of the plan (under item #3, ‘Observation Required’), a nurse would need to make an observation, assess the client, and revise CARE as necessary.

Steps to complete the observation:

1. Arrange to have third party present for observation.
2. Explain what is involved.
3. Tell client where pressure points are.
4. Look at pressure points.
5. Observe for specific conditions.

If no skin problem observed…

1. Document.
2. Revise CARE.

If skin problem is observed…

1. Determine if HCP is involved or aware.
2. Contact HCP within 2 days , or
3. Contact family rep. (see Protocol).
4. Document all activities.
The Skin Observation Protocol in the Nursing Services Chapter has specific Case Manager/Social Worker and nursing activities and interventions dependent on the client situation and whether observation is required or not required. This flow chart provides a quick guide for staff to reference; however, the protocol must be referenced for more specific assignment of responsibilities and response/reporting timelines.

Note: While SW/CMs are not required to perform skin observations, nothing in this Protocol precludes them from observing skin and describing findings as long as nurse involvement also occurs according to the protocol.

Skin Observation may be delayed because…

1. Situation is unsafe and personal safety of nurse may be at risk due to:
   a. Threatening animals.
   b. Sexually inappropriate behavior.
   c. Threatening behaviors.

OR

2. Unable to observe because:
   a. Soiling or unhygienic conditions and no caregiver present to assist or;
   b. Client’s physical condition makes it physically very difficult to observe skin;
   c. Client refuses to allow observation.
      i. Anticipate barriers as much as possible and make arrangements.
      ii. Discuss other resources or approaches with supervisor within 1 working day.
      iii. Reschedule observation within 2 working days.
      iv. Follow usual CM timeframes per LTC manual.
      v. Refer to APS if appropriate.
      vi. Document all activities.

OR

3. Client is cognitively intact, declines observation and there is evidence of negative skin outcome.
   a. Call 911 if emergency.
   b. Identify someone else to observe.
   c. Refer to home health or other HCP.
   d. Verify and document that observation was done.
   e. Collect collateral information.
   f. Educate caregiver using CARE prevention plans.
   g. Refer to APS or CRU as appropriate.
   h. Refer immediately to nurse resource.
   i. Explore other appropriate services.
   j. Discuss.
   k. Document all activities.
   l. Incorporate Challenging Cases protocols.

OR
4. Client is cognitively impaired and meets highest risk indicators and declines observation once or mildly objects to observation
   a. Request permission a second time.
   b. Be sure that client understands as much as possible your request.
   c. Document all activities.

5. Client is cognitively impaired, meets highest risk indicators, consistently refuses; and skin condition over pressure points is unknown. Client has unreliable provider and won’t let anyone else in and/or refuses services to skin integrity over pressure points.
   a. Refer and consult with other services.
   b. Probe to understand basis of refusal.
   c. Refer to APS if appropriate.
   d. Incorporate challenging cases protocols.
   e. Refer for guardianship.
   f. Refer to 911, ER, or CDMHPs if appropriate for involuntary treatment.
   g. Document all activities.

6. Client meets highest risk indicators but observation not completed due to culture or gender.
   a. Consult with supervisor.
   b. Document all activities.