

SKIN CARE Q & A

Q—When does ET/WOC nurse see a patient?

A—When the Physician orders it or if following the Skin Integrity Protocol, the nurse may call in ET nurse for Pressure Ulcer Stage III/IV or necrotic pressure ulcer.

Q—What forms are used for pressure ulcers?

A—General Skin Integrity Protocol, Pressure Ulcer Progress Notes, Charting Flowsheet (or MS Assessment where applicable).

Q—Who is on the Skin Team?

A—EVERYONE. The secretary, PT, Dietician, Nurse Manager, CNA, PCT, Staff Nurse, Doctor and, yes, the ET/WOC Nurse.

Q—What does the General Skin Integrity Protocol address?

A—It addresses treatment for skin tears, incontinent skin problems and treatment of pressure ulcers along with when to consult the ET/WOC nurse (Pressure Ulcer Stage III/IV and necrotic wounds).

Q—How and when does the Physician write an order for ET/WOC nurse intervention?

A—When assistance is required for wound care that is not addressed under the General Skin Integrity Protocol.

Q—What wounds do Physicians manage?

A—Physicians manage venous or arterial ulcers, diabetic ulcers, cellulites of arm/leg, open surgical wounds, traumatic wounds and skin conditions. The physician may write an order for ET nurse assistance with management.

SKIN CARE PRODUCT & USE:

Current products in use are:

***Skin Tear** : Lyof foam: place the shiny side against the skin tear.

***Incontinent skin problems**:

2-1l Perineal/Skin Cleanser - pump bottle product cleans and protects skin. For extra protection use Sensicare Moisturizing Cream. May also use adult diapers, condom catheter or fecal incontinent bag.

***Fungal rash**: use antifungal Mitrazol

***Pressure Ulcers**:

Wound Cleanser - Saf Clens

Hydrocolloid - Duoderm/Signal, AF

Hydrophillic powder - Multidex

Hydrogel - Duoderm gel

Calcium Alginate - Kaltastat

Multi layer dressing - Coverderm

***Beds to reduce or relieve pressure**:

Zoneaire - reduces pressure but must be activated to do so.

Fluid Air by Ker- relieves pressure. May be ordered by following the GSIP

***Relieve Heel Pressure**:

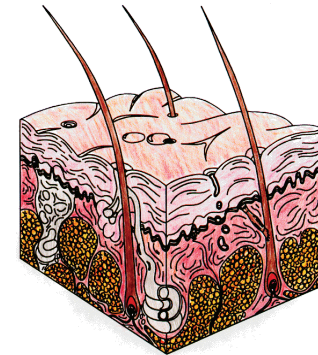
DeRoyal Boot - use for patient that is restless, agitated or non-compliant.

Pillow under lower leg - heel free of pressure with a patient that is totally immobile or compliant



FLORIDA HOSPITAL
Memorial Medical Center

SKIN INTEGRITY PROTOCOL



The purpose of this brochure is to define appropriate and timely assessment with early intervention using The General Skin Integrity Protocol for impaired Skin Integrity

SKIN INTEGRITY: PREVENTION, EARLY INTERVENTION & TREATMENT

PREVENTION IS THE GOLD STANDARD

Skin care to prevent impaired Skin Integrity is provided to every patient in the hospital.

Preventative Care is:

- Turn every 2 hours and as needed
- Increasing activity as allowed
- Good nutrition/hydration
- Prompt incontinence care
- Elevate heels - pressure free
- Education of patient and family

Documentation (Cerner & Paper)

Skin Risk - Upon Admission - on the MS Admission Data under Health History II

Impaired Skin Integrity - Integumentary Section on the Charting Flowsheet (or MS Adult Assessment form) - q12hrs & PRN.

Education - on Interdisciplinary Education Form

Pressure Ulcer Progress Note Form - (paper form) document:

1. upon discovery of the pressure ulcer,
2. weekly on Wednesdays and
3. upon Discharge.

Must be signed by the physician and placed in physician progress note section.

Early intervention begins with the patient's admission to the hospital.

Complete documentation on the daily body check on admission and daily.

WHAT conditions require initiation of the General Skin Integrity Protocol?

- *Skin tears
- *Incontinence skin problems
- *Pressure Ulcers

Other Wounds or Skin Conditions managed by the Physician include:

- *Arterial ulcers
- *Venous ulcers
- *Diabetic ulcers
- *Surgical wounds
- *Traumatic wounds

**Consult the ET/WOC Nurse
Per General Skin Integrity Protocol for
Stage III/IV or Necrotic Wounds
or
Physician's Order**

Pressure Ulcer Stages

Stage I: redness over bony prominence that persists after turning off the area for 30 - 40 minutes

Stage II: a shallow crater or blister over a bony prominence

Stage III: deeper crater over a bony prominence that extends down to but not through the underlying fascia

Stage IV: deep crater over a bony prominence with extensive destruction to muscle or bone or supporting structures

Necrotic covering over Pressure Ulcer - cannot stage necrotic pressure ulcer

General Skin Integrity Protocol

- * Is initiated by the staff nurse when skin destruction is identified or for a patient at risk for a breakdown in order to begin preventative measures.
- * Addresses:
 - skin tears, incontinence-related skin problems, prevention of pressure ulcers, Stage I & II pressure ulcer treatment
- * Is a standing order and placed in the physician's order sections
- * When to consult an E.T. Nurse for Stage III-IV, necrotic ulcers
- * The nurse initiating must sign the protocol.