6-9-25 Weekly Clinical Update

As we continue the series on documentation this week, this issue will focus on best practices for documentation of skin integrity. Maintaining skin integrity and properly documenting wounds are critical responsibilities for nursing facility staff, including licensed nurses, CMAs, and CNAs in addition to practitioners. Proper care and documentation help prevent complications, ensure compliance with regulations, and improve resident quality of care and quality of life.

As you all already know, skin is the largest organ of the body. So many factors influence risk for impaired skin integrity…aging causes dryness and loss of elasticity, immobility, medications, chronic co-morbidities, nutritional & hydration status are just a few. All of these factors need to be considered, care planned & documented during scheduled and routine observations of the skin.

The first documentation requirement includes accurate documentation of the skin. Formal comprehensive skin assessments should be conducted by a licensed nurse within 2-6 hours of admission. Tissue can break down within 2-6 hours of pressure, so if the admission skin assessment occurs beyond 6 hours the facility can and likely will be held responsible for the breakdown UNLESS there is documentation the resident had the breakdown prior to admission. So, in reality, that admission skin assessment should include close review of pre-admission information.

Components of a thorough skin assessment should be completed at the time of admission, then quarterly or with any change in condition & should include:

- General skin conditions including appearance, color, texture, moisture level
    - Signs of dryness, cracking, excessive moisture, abnormal pigmentation
    - Areas of bruising, rashes or lesions
- Skin integrity
    - Open wounds, pressure injuries, any skin breakdown
    - Cuts abrasions, surgical incisions
    - Bruising, skin tears
    - MASD, dermatitis
- Temperature & circulation
    - Variations of skin temperature
    - Signs of compromised circulation, i.e., pallor, cyanosis, mottling
- Turgor (skin elasticity)
    - Gently pinch on forearm or chest (PREFERRED) to assess hydration status
    - If skin remains tented, consider dehydration

- Edema
    - Swelling, particularly in lower extremities
    - Press gently on swollen areas to assess for pitting edema
- Pressure injury risk areas
    - Bony prominences including heels, sacrum, elbows, hips, shoulders, under O2 tubing if applicable, pressure under any devices
    - Complete Braden or Norton scale or any other tool considered “best practice”; this should be completed at admission & weekly x 4 weeks, then monthly x 2 months, then quarterly or with any significant change in status of the resident
- Any/all skin abnormalities or impaired integrity should include:
    - Location (EXACT) anatomical site of the impairment
    - Size: measure length, width & depth
    - Appearance: color, appearance of skin around impairment
    - Drainage: amount, color, consistency of exudate
    - Odor: unusual smells that could indicate infection
    - Pain level: Ask resident to rate pain using standardized scale
    - Interventions: detail interventions including treatments applied, dressing changes, and any physician orders
    - Bruising and skin tears require the same assessment & documentation as a pressure or non-pressure related skin impairment
- If impairment is found, must determine the root cause of the impairment if not already completed

Documentation consistency and accuracy requires:

- Objective language; avoid vague descriptions
- Document immediately after performing the skin assessment or wound assessment
- If your facility uses photographic wound documentation, track wound progression
- Ensure documentation aligns with facility protocols & regulatory guidelines

Licensed nurses must document all skin assessments and wound care assessments along with recording all treatments provided. Remember, the documentation should match the resident’s care plan. Additionally, licensed nurses are responsible for ensuring the resident’s care plan meets all regulatory requirements for comprehensive, individualized and timely care plans. Based on assessment findings, the care plan must be consistent with the resident’s specific conditions, risks, needs, behaviors, preferences, and current standards of practice and must be developed around the goals of the resident. Every skin risk and skin impairment care plan should include:

- Skin integrity management program
    - Support surface management for any/all pressure points identified
    - Specific repositioning plan
    - Specific treatment orders
    - Transfer assistance to avoid shearing and friction
- Bowel and/or bladder management program
- Pain management program
- Infection Control management program
- Nutritional and hydration management program

CNAs are responsible for actively participating in the development of the resident's skin integrity care plan and following the interventions included in the care plan. They are also responsible for performing skin observations during any/all cares provided to the resident. Any/all abnormalities should be reported to a licensed nurse immediately upon observations. If the INTERACT system is used, a STOP-AND-WATCH should be completed and provided to the nurse to support the reporting of abnormalities.

CMAs are responsible for documenting all medications and treatments provided to the resident related to skin integrity. Additionally, CMAs are responsible for implementing all care plan interventions and reporting any changes that might be needed to the care plan or resident observations during cares. Again, the INTERACT STOP-AND-WATCH is an evidence-based practice that improves communication and collaboration.