Spring Grove Hospital Center

Skin Integrity/Wound Care Assessment Record

Department of Nursing

Policy and Procedure **SGHC NP0992**

Purpose

To provide guidelines to document assessments and reassessments related to skin integrity including but not limited to patients who are at high risk for skin breakage and patients that have actual skin breakage i.e., lacerations, burns, decubitus, surgical wounds, etc. The Skin Diagram located in the Interdisciplinary Assessment-Admission form, Weekly Skin Care Record, and the Wound Care Flow Sheet is designed to provide a comprehensive record for documentation of skin abnormalities and ongoing reassessment.

Scope

This policy applies to all patient units.

Policy

It is the responsibility of all licensed nursing staff to assure quality care and documentation of skin integrity. The nurse is responsible for assessing, reassessing, and documenting skin integrity for patients. The initial assessment by a Registered Nurse occurs upon admission. All subsequent reassessments occur whenever it is observed by the nurse that a patient is at high risk for potential skin breakage when the patient complains of skin irritation or when there is actual skin breakage.

Procedure

A. **Skin Diagram** All actual skin integrity observations identified on admission must be noted on the Skin Diagram located in the Interdisciplinary Admission Assessment Form. Such observations may range from scars / previous surgical scars, hernias, amputation(s), ulcerations, bruises, wounds, tattoos, etc. The nurse must mark all significant abnormalities in the appropriate sections of the Skin Diagram using an arrow to record the date of initial skin assessment and documentation on the Skin Diagram. Each entry recorded on the Skin Diagram must be initialed by the nurse and documented on the text box to the left of the Skin Diagram.

B. **Weekly Skin Care Record**

1. This form is used to document nursing assessments and reassessments of patients who have been identified by the nurse as being high risk for potential skin breakage. High risk includes but is not limited to patients that are bed ridden, non-ambulatory, and incontinent, in casts, or having bony prominences i.e., skin integrity is compromised but not actually broken.
2. The Registered Nurse (RN) is responsible for initiating the Weekly Skin Care Record and notifying the Somatic physician of the patient's skin integrity status.
3. The nurse must record his/her reassessment for such high-risk patients on a weekly basis using the Weekly Skin Care Record.
4. The Weekly Skin Care Record is to be filed in the Treatment Graphs section of the medical record.

C. **Wound Care Flow Sheet**

This form is used to document nursing assessments and reassessments of patient who have been identified by the nurse as having actual skin breakage. Skin breakage includes but is not limited to observed broken skin such as ulcerations, skin tears, surgical wounds, etc. The RN must do the initial and ongoing assessment of wound.

1. The assessment of the wound must include specific descriptions related to appearance, size and characteristics of the wound as guided by the Wound Care Flowsheet.
2. Any wound care treatment as ordered by the physician, must be documented on the Wound Care Flowsheet.
3. Each entry must be initialed by the recorder and fully authenticated on the bottom of the Wound Care Flowsheet.
4. Wound description, status, and treatment must be summarized in the monthly advocate note.
5. The RN is responsible for initiating the Wound Care Flow Sheet at the time the condition is noted.
6. The Wound Care Flow Sheet is to be filed in the Treatment Graphs section of the medical record.

D. **General Surgical Wound Care**

1. All surgical wound care shall follow the physician's order.
2. All dressing changes must be done using sterile techniques.

3. The nurse shall observe the surgical wound dressing every shift and document status in the progress note section of the medical record.
4. Report any signs of infection or dehiscence to the physician immediately (redness, swelling, induration, tenderness, separation of the incision, odor, exudates, etc.) and document in the medical record.

Attachment: Weekly Skin Care Record
Wound Care Flowsheet

Approved by

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