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# Nursing Skin Integrity Guidelines: A New Approach to Skin Care

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# Nursing Skin Integrity Guidelines: A New Approach to Skin Care

Coming May 2014



**CENTRA**CARE  
St. Cloud Hospital

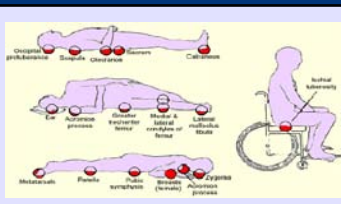


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## What is Nursing Skin Integrity Guidelines?

- A nursing driven order to provide evidence based skin integrity interventions.
- Provides a streamlined process for immediate application of best practice interventions for identified skin impairments.
- The interventions can be implemented based on assessment findings and clinical judgment.
- Provides a guideline for consulting the WOC Nurse including: when wounds are not healing, all pressure ulcers, and ostomy needs.

## Pressure Points = Pressure Ulcers



## Remember: Redistribute Pressure

- Turn every two hours
- Elevate heels
- Consider a Mattress Overlay
- Remove all tubes and lines from under the patient

## Which Guideline Do I Choose?

### Incontinence



### Select the Incontinence Guidelines

Guideline: Skin Altered from Incontinence

1. Use absorbent pads that wick moisture away from the body (avoid disposables when possible)
2. Skin care BID and after each incontinent episode to include:
  - Cleanse skin with personal cleanser/barrier lotion, soap and water. Dry.
  - Apply 1/8th layer of skin barrier ointment (Aloe Vesta) for loose stools or IAD (incontinence associated dermatitis).
  - RN to assess continuous loose stools for use of fecal management system and CalmoSeptine ointment.
3. Notify provider to assess for use of FMS and CalmoSeptine ointment... Routine, Normal, FYI, Starting today For 1 Occurrences, Qty:1

### Suggested Interventions:



### Reddened Folds



### Select the Skin Folds Guidelines

Guideline: Skin Folds

1. Cleanse skin with cleanser or soap and water. Dry.
2. Consider use of InterDry® between skin folds. Make sure part of the InterDry® is exposed to air so that moisture can evaporate. \*Do not use in folds that are exposed to incontinence. Remove Interdry before MRI.
3. Notify provider to assess for antifungal powder Routine, Normal, Starting today, Qty:1
4. If incontinent, apply thin layer of skin barrier ointment (i.e. Aloe Vesta). Routine, Normal, FYI, Starting today For 1 Occurrences, Qty:1

### Suggested Interventions:



### Deep Tissue Injury or Stage 1



### Select the Stage 1/Deep Tissue Injury Guideline

Guideline: Skin Stage 1/ Deep Tissue Injury (DTI) / Intact Blister: Stage 1 is INTACT skin that is discolored that does NOT blanch. If the redness blanches, it is not considered a pressure ulcer/injury. DTI (deep tissue injury) is intact purple, maroon and/or dark tissue that does NOT blanch.

1. Consult WOC nurse if pressure related injury even with intact skin
2. Implement pressure reduction/redistribution measures.
3. Consider protective dressing for friction/shear (i.e. Mepilex foam)
4. Discontinue order and document resolved when area blanches. Routine, Normal, FYI, Starting today For 1 Occurrences, Qty:1

### Suggested Interventions:



### Stage 2



### Select the Stage 2 or Abrasion Guideline

Guideline: Skin Partial Thickness/Stage 2 or Abrasion:

1. Consult WOC Nurse if pressure related injury
2. Implement pressure reduction/redistribution measures.
3. Clean with normal saline or wound cleanser and dry gauze.
4. Apply a topical therapy:
  - a. Apply foam dressing, if minimal to large exudate.
  - b. Apply barrier ointment if very small buttock wound or if dressing is not feasible
5. If wound located on extremity without palpable pulse, apply foam and notify MD and WOC
6. Change foam dressing twice weekly and as needed for 80% strikethrough drainage is present

### Suggested Interventions



### Stage 3, 4 or Unstageable



### Select the Stage 3, 4, or Unstageable Guideline

Guideline: Skin Full Thickness Wounds: Full thickness wounds are stage 3, 4 or unstageable pressure ulcers, wounds with depth or wounds covered with yellow, brown or black tissue (excluding scabs), vascular, diabetic, open surgical wounds, fistulas.

1. Consult WOC Nurse
2. Implement pressure reduction/redistribution measures.
3. If dry tan, brown or black eschar is present, keep clean, dry and intact. Do not apply moisture
4. Clean with normal saline or wound cleanser and dry gauze.
5. If depth is present, fill wound with moist NS Kerlix (one piece per wound) and cover with ABD dressing.
6. Change dressing daily and as needed when 50% strikethrough drainage is present. Routine, Normal, FYI, Starting today For 1 Occurrences, Qty:1

### Suggested Interventions



### Skin Tears



### Select the Skin Tear Guideline

Guideline: Skin Tear: Skin Tear is an inadvertent removal of the epidermis by mechanical means.

1. Approximate edges when possible and secure with steristrips
2. Clean with normal saline or wound cleanser and dry gauze.
3. If skin tear is less than 3-4cm:
  - a. cover with foam dressing (i.e. Mepilex foam)
4. If skin tear is greater than 3-4cm, multiple skin tears, bleeding or copious drainage:
  - a. apply Cutaneous adhesive remover (i.e. Karlix).
  - b. Change dressing daily and PRN breakthrough drainage.
5. Consult WOC
6. Avoid adhesives in general to prevent future skin tears. If adhesives must be used, utilize adhesive remover (i.e. Adhesion Wizard)

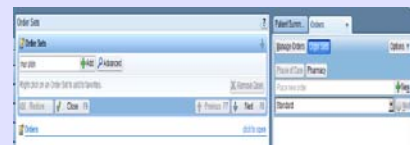
### Suggested Interventions



\*\* Photos obtained from www.bing.com/images\*\*

## How to Place the Order?

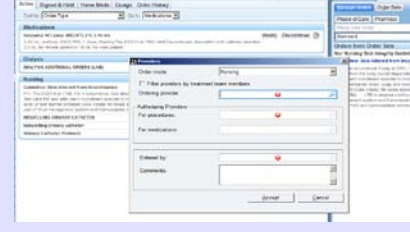
1. Select Manage Orders and Order Sets
2. Search Nursing Skin Integrity



3. Select the appropriate guideline



4. Sign the Nursing Order



## Where to Find the Interventions?

Each shift review Skin Integrity Orders that are listed within the Shift Report:

