Skin Lesions Template

The next template which is unique to the Nursing Home Suite of Templates is Skin Lesions. The full name of the template is "**Clinically Unavoidable Skin Lesions**." Skin lesions are common in long-term care facilities, and often are unavoidable. This template

Skin lesions are common in long-term care facilities, and often are unavoidable. This template helps identify the patients who are at risk of unavoidable skin lesions.

The template is organized into three vertical sections.

The left-hand section has two columns.

Risk Factors – 22 conditions are listed which contribute to the patient's being at risk for "Clinically Unavoidable Skin Lesions." These should be reviewed and any risk factors which apply to the patient should be documented by checking the box next to it. These are in demographic fields, which means that once they are checked, they remain checked in subsequent visits until they are unchecked.

Risk Factors		Skin Condition			Return
Severe COPD	Chr. ES Liver DX.	Poor skin tu	rgor		
Diabetes	Chr. ES Heart DX.	Muscle was	sting		Wound Protocol
Severe PVD	Immunosuppresion	Cachexia			Call to Family
Chr. Bowel Inc.	Full Body Cast	Calf tenderr	ess		
Chr. Uninary Inc.	Steroid Therapy	Bilateral ede	ima		Document
Paraplegia	Radiation Therapy	Reduced un	inary output		
HOB Increase	Renal Dialysis	Weight loss	(more than 5	% in one month)	Risk Assessment
Guadraplegia	Terminal liness		ealed decubit	tus 11	10
E Sepsis	Bed Bound	Mobility			Waterlow Risk Assessmen
Chr. ESRD	Comatose/Semicomatose due to medical condition	Mental statu	15		Norton Risk Assessment
Unable to turn and	position		22		Braden Risk Assessment
aboratory Results (*	may indicate mainutrition/dehydration)	Check for New Labs			2
MCV	II Serum Transfe	errin	11	*(< 180 mg)	Help Documents
MCH Hab	11 Serum Albu		11	*(< 3.0 q/d) *(< 5.1 q/d)	Skin Care in Elderly Patients
ngo	1 Total Pro	AGO 1	1.00	(4.5.1 (pd)	Skin Integrity
Skin Care		Mobility			Olin Care Oleaners
Cleanse w Granules Panifil Oint Bactoban TAO Accuzyme	Ointment Care for Dry Skin	E Do no	off affected a t get up in ch e up for		Skin Care Glossary

Laboratory Results -

There are six laboratory results here which impact the ability of the patient to heal wounds and/or which indicate the presence of chronic malnutrition which would prevent wound healing. There is a button entitled **Check for New Lab** which allows you to import the most recent lab values on this patient. Additional information on the patient's nutritional status can be found on the Nutrition Template. To learn more about the Nutrition template, visit the <u>Nutrition</u> tutor. To

review the tests necessary to evaluate the patient's nutritional status, see the Lab Charge Posting template



Intervention ---

This section addresses 6 skin-care options and 3 Mobility options for improving skin care. However, in the presence of the above mentioned Risk Factors and in the presence of clinically unavoidable malnutrition, maintaining the integrity of the skin is not possible.

tisk Factors		Skin Condition			Return
Severe COPD	Chr. ES Liver DX.	Poor skin turg	or		
T Diabetes	Chr. ES Heart DX.	Muscle wastin	ng .		Wound Protocol
Severe PVD	Immunosuppresion	Cachexia			Call to Family
Chr. Bowel Inc.	Full Body Cast	Calf tendernes	5:8		
Chr. Urinary Inc.	Steroid Therapy	F Bilateral edem	a		Document
Paraplegia	Radiation Therapy	Reduced uring	ary output		
HOB Increase	Renal Dialysis	Weight loss (r	nore than 5% i	n one month)	Risk Assessment
C Quadraplegia	Terminal liness	History of hea	led decubitus	11	Nak Asacsallicin
E Sepsis	E Bed Bound	Mobility			Waterlow Risk Assessment
Terminal Cancer	Comatose/Semicomatose	Mental status			
Chr. ESRD	due to medical condition				Norton Risk Assessment
Unable to turn and	position				
a contraction of the first of the					Braden Risk Assessment
	may indicate mainutrition/dehydration) Che	ack for New Labs			Braden Risk Assessment
	Contraction of the second s		11	*(< 180 mg)	
aboratory Results (*	may indicate mainutrition/dehydration) Che		11		Help Documents
aboratory Results (* MCV MCH	may indicate mainutrition/dehydration) Che			*(< 3.0 q/d)	
aboratory Results (* MCV	may indicate mainutrition/dehydration)Che Che Serum Transferrin Serum Albumir		11		Help Documents
MCV MCV MCH Hgb	may indicate mainutrition/dehydration) Che		11	*(< 3.0 q/d)	Help Documents Skin Care in Elderly Patients Skin Integrity
Aboratory Results (* MCV MCH Hgb Intervention Skin Care Cleanse v	may indicate mainutrition/dehydration) Che	Mobility	11	*(< 3.0 q/d) *(< 5.1 q/d)	Help Documents Skin Care in Elderly Patients
Aboratory Results (* MCV MCH Hgb Intervention Skin Care Cleanse v Granules	may indicate mainutrition/dehydration)Che Serum Transferrin Serum Albumin Serum Albumin TTotal Protein 	Mobility	// // affected area	*(< 3.0 qxld) *(< 5.1 qxld)	Help Documents Skin Care in Elderly Patients Skin Integrity
Aboratory Results (* MCV MCH Hgb Intervention Skin Care Cleanse v Granules Panifil Om	may indicate mainutrition/dehydration)Che Serum Transferrin Serum Albumin Serum Albumin T T T 	Mobility	// // affected area	*(< 3.0 q/d) *(< 5.1 q/d)	Help Documents Skin Care in Elderly Patients Skin Integrity
Aboratory Results (* MCV MCH Hgb Intervention Skin Care Cleanse v Granules	may indicate mainutrition/dehydration)Che Serum Transferrin Serum Albumin Serum Albumin T T T 	Mobility	// // affected area	*(< 3.0 qxld) *(< 5.1 qxld)	Help Documents Skin Care in Elderly Patients Skin Integrity

At the very bottom of this left-hand section is a button entitled **Care for Dry Skin**. When launched 8 options for caring for dry skin appear. There are boxes which allow the selecting of certain options which will then appear on the chart note.

isk Factors		Skin Condition	Return
Severe COPD	Chr. ES Liver DX	Poor stin turgor	
Diabetes	Chr. ES Heart DX	Guides Dry Skin	
Severe PVD	[Immunosuppresk		
Chr. Bowel Inc.	Full Body Cast	Skin Care for Dry Ski	n
Chr. Urinary Inc.	Steroid Therapy	Onin Oare for Dry Oni	••
Paraplegia	Radiation Therap		
HOB Increase	Renal Dialysis	Take fewer showers or baths (2 to 3 per week is fine). Keep them	short and use warm, not hot, water
Guadraplegia	Terminal liness	Apply lotion over your whole body after you towel off	
Sepsis	E Bed Bound		
Terminal Cancer	Comatose/Semic	Always apply lotion immediately after swimming or in a chlorinated p	pool or sitting spa
Chr. ESRD	due to medical c	C Avoid saunas	
Unable to turn and	position	Apply lotion all over your body at bedtime	
aboratory Results (*	may indicate malnutritio	Use soaps for designed for dry skin, such as glycering soap with o	leansing cream, and rinse well
MCV	11	Consider using a humidifier on cold, dry winter days	
	11		
MCH		Drink more fluids but avoid alcohol, spicy foods, and ceffeine	
Hgb	11		
tervention		OK Cancel	1
Skin Care			1
Cleanse w	ith Dial soap and water		
Granules		Do not get up in chair	
Panifil Oint	ment	May be up for hours dai	N
E Bactoban	Ointment Care for	Dry Skin	
TAO			
Accuzyme			

Middle Section of Clinically Unavoidable Skin Lesions Template

Skin Condition – this provides the opportunity to document 10 skin conditions which contribute to Clinically Unavoidable Skin Lesions.

Right-hand section of Clinically Unavoidable Skin Lesions Template

NH Master – this is a navigation button back to NH Master Template

sk Factors		600 P	Skin Condition			Return
Severe COPD	Chr. ES Liver	774300	Poor skin tur	T 5330		Wound Protocol
Diabetes	Chr. ES Heart	55521 h	Muscle was	ting		Wound Protocor
Severe PVD			Cachexia			Call to Family
Chr. Bowel Inc.	Full Body Cas		Calf tendern	22.50		Document
Chr. Urinary Inc.	Steroid Thera	N. 7. (Ellateral ede			Document
Paraplegia	Radiation The	Searce of the second	Reduced uni			
HOB Increase	Renal Dialysis		1444 40 1000 C Prob 10 20	100425-0500000CS	% in one month)	Risk Assessment
Quadraplegia	Terminal Illnes	IS	History of he	saled decubit	us 1 / /	
Sepsis	E Bed Bound		Mobility			Waterlow Risk Assessmen
Chr. ESRD	Cornatose/Se due to medica	Contraction of Contract	Mental statu	S		Norton Risk Assessment
Unable to turn and						
		rition/dehydration) Ch	eck for New Labs	Ê		Braden Risk Assessment
MCV		Serum Transferri		11	*(< 180 mg)	Help Documents
MCH	11	Serum Albumi	in [11	*(< 3.0 q/d)	
Hab		Total Protei		11	- (< 5.1 g/d)	Skin Care in Elderly Patients
ervention		Teles Trees				Skin Integrity
in Care			Mobility			Skin Care Glossary
	vith Dial soap and wa	ter and rinse well		ff affected a	7.7. T	
Granules			(0.00120012)	get up in ch		
Panifii Oin			May b	e up for	hours daily	f
Bactoban	Ointment Car	e for Dry Skin				
T TAO						

Wound Protocol – this launches the Wound Protocol pop-up which gives treatment guidelines for Stage II wounds and for Stage III/IV Wounds. This is a different guideline than that for the <u>Skin Tear Guidelines</u>

Risk Factors Severe COPD Diabetes Severe PVD Chr. Bowel Inc.	Chr. ES Liver DX. Chr. ES Heart DX. Immunosuppresion Full Body Cast	Skin Condition Poor skin turgor Muscle wasting Cachexia Calf tendemess	Wound Protocol Call to Pamily
Chr. Urinary Inc. Paraplegia HOB Increase Quadraplegia Sepsis	Steroid Therapy Radiation Therapy Renal Dialysis Terminal Illness Bed Bound	ound Protocal Wound	Guidelines
MCV MCH Hgb Intervention Skin Care Cleanse w Granules	th Dial scap and water and rin	Stage II Wound Vitamin C 500 mg. 1 po BID Zinc Sulfate 220 mg. 1 po QD for 1 month Albumin Level Transferrin Level Muttivitamin with minerals 1 po QD Prealbumin Level if weight loss occurs OK	Stage III / IV Wound Vitamin C 500 mg. 1 po BID Zinc Sulfate 220 mg. 1 po QD until resolved Albumin Level Transferrin Level Mutivitamins with minerals 1 po QD Prealbumin Level if weight loss occurs Cancel Cancel
Panifil Oint Bactoban TAO Accuzyme Other	Dintment Care for Dry Skin	May be up for	hours daily

Call to Family – this launches the Call to Family Record. For details see below. **Document** – this creates a document for the chart from the evaluation of **Clinically Unavoidable Skin Lesions.**

Beneath this are two functions

Risk Assessment

• Waterlow Risk Assessment -- this is a standardized risk assessment from 11 categories which indicates whether or not the patient has a clinically unavoidable skin lesion risk.

JdM/Height for Height Average Above Average Obese Below Average otherece Consider/Catheter Occasional incontinence Catheter/Incotinence Feces Doubly incontinent in Type and Visual Risk Areas Heathy Tassue Paper, Dry, Edemator Discolored Evolven	Return Sex C Male C Fenale Age C 14 - 49 C 50 - 64 C 50 - 64 C 65 - 74 C 75 - 80 C > 81 Tissue Mainutrition C Terminal Cachesia C Cardiac Failure or Peripheral Vascular Disease C Anenia C Smoking
obity C Fully C Restess.Fidgety C Resticed C Resticed C Traction C Chair-Bound	Medication C Anti-Inflammatories, Steroids, or Cytotoxics C None of the Above Major Surgery/Trauma C Orthopsedic Below Waist, Spinal C OR > 2 Hours
pette C Average C Poor NO Tube or Fluids Only F HEM / Anorexia Score	Neurological Deficit C Diabetes, CVA, MS, Paraplegia C None of the Above

• Norton Risk Assessment – this is the Norton Risk Assessment Clinically Unavoidable Skin Lesions which assesses the patient from 5 categories. A score is produced and indicates the patient's risk for clinically unavoidable skin lesions.

	orton Risk Assessment	
Clinica	lly Unavoidable Skin Lesions	Return
Physical Condition	Mobility	
C Good	C Ful	
C Fair	C Slightly Limited	
C Poor	C Very Limited	
C Bad	C Immobile	
Mental Condition	Incontinence	
C Alert	C Not	
C Apathetic	C Occasionally	
C Confused	C Usually of Urine	
C Stuporose	C Doubly	
Activity		
C Ambulant		
C Walks with Help		
C Chair-Bound	Score	
C Bed-Bound	A score less than 16 indicates patient at risk.	
Previous Re	sults A score less than 16 indicates patient at risk.	
Enc	ounter Date: Time Score	
	2 · · · · · · · · · · · · · · · · · · ·	
1	>	

• **Braden Risk Assessment** – Baden Scale Clinically Unavoidable Skin Lesions. This is based on 6 categories of evaluation and gives a score which indicates whether or not the patient is susceptible to clinically unavoidable skin lesions.

Completely Limited		Mobility C Completely Immobile C Very Limited
C Slightly Limited No Impairment		C Slightly Limited No Limitation
in Moisture		Nutrition
C Completely Moist Very Moist C Occasionally Moist Rarely Moist		C Very Poor C Probably Inadequate C Adequate C Excellent
tivity		Friction and Shear Help
C Bedfast		C Problem
C Chairfast		C Potential Problem
C Walks Occasionally		C No Apparent Problem
C Walks Frequently		
Score	Assessment	1
	_	
evious Results		
Encounter Date: Time	Score	Assessment
12/02/2009 08:29 AM	14	The patient has a high risk for developing clinically unavoidable skin lesions.

Note: On **the Braden Assessment** there is a pop-up entitled **Friction and Shear** which expands on this risk factor.

Completely Moist Very Poor Very Moist Probably Inadequate Cocasionally Moist Adequate Rarety Moist Excellent Activity Friction and Shea Chairfast Problem Valks Occasionally Walks Occasionally Walks Frequently Score Assessment Skin Braden Fric Problem Friction and Shear Problem Score Assessment Problem Requires moderate to maximum assistance in moving. Complete lifting with against sheets is impossible. Frequently sildes down in bed or chair, requir repositioning with maximum assistance. Spasticity, confractures or agtedic repositioning with maximum assistance. Spasticity, confractures or agtedic	
Completely Limited Completely limited Very Limited Sightly Limited Sightly Limited Sightly Limited No Impairment No Impairment Completely Moist Very Very Limited Completely Moist Very Poor Very Moist Probably Inadequate Occasionality Moist Adequate Rarely Moist Excellent Metrix Problem Bedfast Problem Score Assessment Freevious Results Friction and Sheat Sheats is impossible. Frequently side down in bed or chair, require repositoring with maximum assistance. Spasticity, contractures or agitable to amost minitorin. Yrevious Results Potential Problem Encounter Date: Time Score Assessment Encounter Date: Time Score Assessment Moves feebly or requires minimum assistance. During a move skin probable of ender or bed most of the time but occasionally side down. Noves feebly or requires minimum assistance. During a move skin probable of ender or bed most of the time but occasionally side down.	I
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Kin Moisture Nutrition Completely Moist Yery Poor Occasionally Moist Adequate Rarely Moist Excellent Nutrition Probably Inadequate Rarely Moist Excellent Nutrition Probably Inadequate Cocasionally Moist Probably Inadequate Bedfast Problem Chairfast Problem Walks Occasionally Skin Braden Fric Walks Occasionally Friction and Sheat Value Problem Score Assessment Encounter Date: Time Score Izo2/2009 06:29 AM 14 The patient hest Moves feebly or requires minimum assistance. During a move skin probable extent against sheets, chair, restraints or other devices. Maintains relative in chair or bed most of the time but occasionally skide down.	
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○ Very Moist ○ Probably Indequate ○ Occasionally Moist ○ Adequate ○ Rarely Moist ○ Excellent Interview Friction and Shea ○ Bedfast ○ Problem ○ Chairfast ○ Problem ○ Walks Occasionally ○ Problem ○ Walks Prequently Skin Braden Fric Ywalks Prequently Skin Braden Fric Problem Friction and Shear Problem Skin Braden Fric Problem Friction and Shear Problem Skin Braden Fric Noves Frequently Friction and Shear Problem Problem Problem Friction and Shear Problem Skin Braden Fric Noves Frequently Store against sheets is impossible. Frequently slides down in bed or chair, require repositioning with maximum assistance. Spasticity, contractures or agitation to almost constant friction. Potential Problem Moves freely or requires minimum assistance. During a move skin probable extent against sheets, chair, restraints or other devices. Maintains relative in chair or bed most of the time but occasionally slide down.	
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Previous Results Requires moderate to maximum assistance in moving. Complete lifting with against sheets is impossible. Frequently slides down in bed or chair, require repositioning with maximum assistance. Spasticity, confractures or agitation to almost constant friction. Encounter Date: Time Score Assessment 12/02/2009 08:29 AM 14 The patient has Moves feebly or requires minimum assistance. During a move skin probabiliextent against sheets, chair, restraints or other devices. Maintains relatives in chair or bed most of the time but occasionally slide down.	
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extent against sheets, chair, restraints or other devices. Maintains relative in chair or bed most of the time but occasionally slide down.	
in chair or bed most of the time but occasionally slide down.	
	vely good position
No Apparent Problem	
Moves in bed and in chair independently and has sufficient muscle strengt	ngth to lift up
completely during move. Maintains good position in bed or chair.	
OK Cancel	

Help Documents

- Skin Care in Elderly Patients this document gives more detail about skin care in the elderly.
- Skin Integrity this is an excellent discussion with pictures of the integrity or lack of integrity of the skin.
- Skin Care Glossary this defines 16 terms commonly used in evaluating the skin.

k Factors		Skin Conditi	on		Return
Severe COPD	Chr. ES Liver DX.	Poor s	kin turgor		
Diabetes	Chr. ES Heart DX.	T Musck	wasting		Wound Protocol
Severe PVD	Immunosuppresion	Cache	xia		Call to Family
Chr. Bowel Inc.	Full Body Cast	Calf te	nderness		Conston annuy
Chr. Urinary Inc.	Steroid Therapy	Ellatera	al edema		Document
Paraplegia	Radiation Therapy	T Reduc	ed urinary output		
HOB Increase	Renal Dialysis	C Weight	loss (more than 5%	in one month)	Risk Assessment
Guadraplegia	Terminal liness	History	of healed decubitus	11	KISK ASSESSITICIK
C Sepsis	F Bed Bound	Mobility	ř.		Waterlow Risk Assessmen
Terminal Cancer	Cornatose/Semicomatose	Mental	status		
Chr. ESRD	due to medical condition				Norton Risk Assessment
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	may indicate malnutrition/dehydra	ation) Check for New I	abs		Braden Risk Assessment
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MCV	may indicate mainutrition/dehydra	rum Albumin		*(< 3.0 q/d)	
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MCV	may indicate mainutrition/dehydra	rum Albumin		*(< 3.0 q/d)	Help Documents
boratory Results (* MCV MCH Hgb	may indicate mainutrition/dehydra	rum Albumin		*(< 3.0 q/d)	Help Documents Skin Care in Elderly Patient Skin Integrity
MCV MCV MCH Hgb ervention in Care	may indicate mainutrition/dehydra	Transferrin rum Albumin Total Protein Mobility		*(< 3.0 q/d) *(< 5.1 q/d)	Help Documents
MCV MCV MCH Hgb ervention in Care	may indicate malnutrition/dehydra	Transferrin rum Albumin Total Protein Mobility e well		*(< 3.0 q/d) *(< 5.1 q/d)	Help Documents Skin Care in Elderly Patient Skin Integrity
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