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# Giving Time Back: Implementing a Electronic Nursing Protocol for Skin Care

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# Giving Time Back: Implementing a Electronic Nursing Protocol for Skin Care

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## Purpose Statement

To improve the accessibility of evidence based skin care interventions for the clinical nurse without the need of a CWOCN consult.

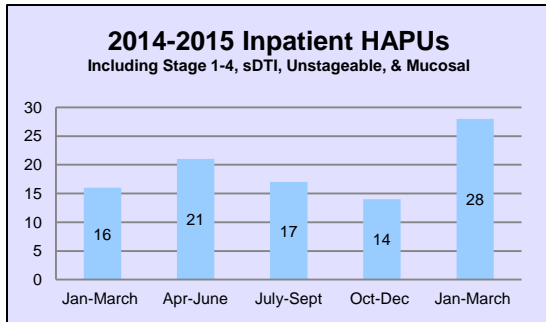
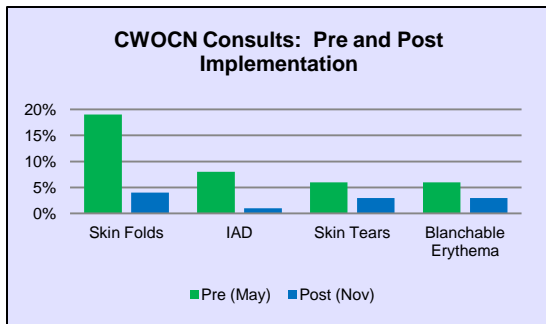
## Why a protocol?

- Eliminate the number of CWOCN consults for skin impairments that can be managed by a clinical nurse.
- 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 direction for consulting the CWOCN including:
  - identification of all pressure ulcers (present on admission or hospital acquired)
  - wounds or impairments are not healing
  - ostomy needs
  - Skin tears greater than 3-4 cm.

## Staff Education

- Posters, that included photos of the impairment paired with the correct guideline and product.
- Computer based training modules
- Unit based skin champions and CWOCN providing 1:1 feedback
- Pocket cards
- Newsletter articles
- Skills stations – identify the impairment and select the correct guideline

## Pre/Post Measures



	Average Hospital Daily Census	CWOCN New Consults over 3 weeks
Pre-Measure	376	292
Post-Measure	370	213



## Practice Change

1. Identify the skin impairment
2. Search order sets



3. Select the correct guideline

**Nur Nursing Skin Integrity Guideline [2462]**

**Guideline**

**Harming Skin Integrity Guideline:**  
Surgical wounds followed by surgeon will have the wound care orders deferred to them, unless Wound, Debrim, Containment (WOC) nurses are consulted by the surgeon for that wound. Utilize guidelines as a resource.  
RN to assess if need for WOC consult.  
Consult WOC nurse for assessment with skin care assessment or intervention recommendations if protocol not effective, or if pressure injury present.  
The WOC consult is to set up a Plan of Care that the nurses will follow. The WOC will not complete all routine dressing changes.

**Skin Integrity Guidelines**

Guideline: Skin Altered from Incontinence

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

Guideline: Skin Stage I / Deep Tissue Injury (DTI) / Intact Blister Stage I 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

WOC nurse consult

Reason for Consult/Notification?  
What type of evaluation should be performed?  
Qty: 1

4. Each shift review required interventions

**Skin Integrity Orders (Through next 24h)**

Start: 02/05/15 1322

Guideline: Skin Altered from Incontinence [1171734] FYI Complete Discontinue

Comments: 1. Use absorbent pads that wick moisture away from the body (avoid diapers/baths when possible).

2. Skin care BID and after each incontinent episode to include:
  - Cleanse skin with perineal cleanser/barrier lotion, soap and water. Dry.
  - Apply THIN layer of skin barrier ointment (Aloe Vera) for loose stools or IAD (incontinence associated dermatitis).
  - RN to assess continuous loose stools for use of fecal management system and advanced barrier ointment, i.e. Calazone, Calmosopline.
3. Notify provider to assess for use of FMS

Ordered: 02/05/15 1321

## References

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