



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND DISABILITY SERVICES ADMINISTRATION  
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**HCS MANAGEMENT BULLETIN**

**03-29**

April 18, 2003

**TO:** Home and Community Services Regional Administrators  
Area Agency on Aging Directors  
Division of Developmental Disability

**SUBJECT:** Final version of the Skin Observation Protocols

Attached is the final version of the Skin Observation Protocol posted with Information Memorandum 02-23 (July 30, 2003). This protocol will be implemented with the Comprehensive Assessment and Resource Evaluation (CARE) automated assessment in each HCS and DDD region and PSA for the Area Agencies on Aging.

Clarifications from the DRAFT posted with IM 02-23 were made in the following areas:

1. Identification of Nurse Delegators and other contracting nursing resources as able to perform assessment functions, including skin observation for clients with highest risk indicators;
2. Referencing of the Prevention Plans for Skin Breakdown over Pressure Points;
3. Referencing CARE skin assessment screens; and
4. Updating references to the protocols established for Challenging Cases.

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**Attachments:**

[MB-03-29 PRESSURE SORES Pictures Attachment A.doc](#)

[MB-03-29 Attachment B \(IM02-23 Attachment draft change 04-14-03 untracked\).doc](#)

**AGING & DISABILITY SERVICES ADMINISTRATION**

**SKIN OBSERVATION PROTOCOL  
PHOTOGRAPHS & DESCRIPTIONS OF PRESSURE ULCERS**

**Stage I**

An observable pressure-related alteration of intact skin with indicators as compared to an adjacent or opposite area on the body. These indicators may include changes in one or more of the following: skin temperature, tissue consistency, and/or sensation. In lightly pigmented skin, the ulcer appears as a defined area of persistent redness. In darker skin, the ulcer may appear with persistent red, blue, or purple hues.

**Stage II**

Partial-thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

**Stage III**

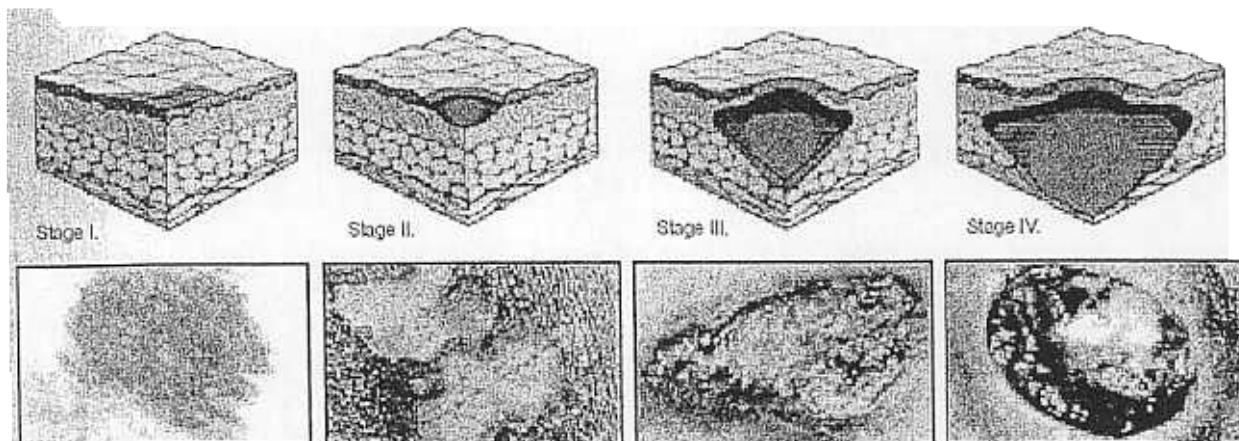
Full-thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

**Stage IV**

Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts may be associated with Stage IV ulcers.

Stage I ulcers may not always be diagnosed reliably in patients with darkly pigmented skin.  
When eschar is present, a pressure ulcer cannot be staged accurately until eschar is removed.  
Be alert to pressure-induced pain in patients with casts or support stockings.

Adapted from Statement on Pressure Ulcer Prevention Copyright, 1998. Used with permission of National Pressure Ulcer Advisory Panel.



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## Assumptions

The protocols are based on the following assumptions:

1. It is our responsibility to assess the client's care needs, which include health care issues. Addressing identified issues in the client's service plan is integral to a comprehensive plan of care.
2. Skin observations do not need to be done for every client. It is estimated that the protocols will apply to 7-10% of the caseload, those clients who are identified using the CARE assessment tool as positive for the highest risk indicators. The number of clients who require direct observation will be reduced further by those clients who already have an appropriate plan in place.
3. HCS Nurses, AAA Nurses, and contracting nursing resources will perform assessment functions, including skin observation. Clients in residential facilities receiving services from a contracting delegating nurse will be referred to the contracting delegating nurse for skin observation functions according to the protocol.
4. Assessing the skin has always been an expectation of case managers as part of a comprehensive assessment, but we largely relied on self-reporting and protocols were not in place.
5. There are many indicators that place a person at risk for skin breakdown over pressure points. Out of these the indicators that place a person at highest risk will trigger the protocols for skin observation.
6. Case Managers are expected to gather indicator information, identify, document and make appropriate referrals according to protocols.
7. It is expected that there will be a reasonable effort to schedule the observation home visit when there will be a third party present. However, if the assessment triggers the skin observation protocol, the HCS Community Nurse Consultant, AAA Nursing Services, or other contracting nursing resource is expected to complete the observation if the protocol indicates the need, and within any applicable timelines in the protocol.
8. HCS Social Workers and Aging Network Case Managers will not continue authorization of services and payment, but will attempt to offer alternatives, when services cannot be delivered according to the plan of care or services are not being adequately delivered due to caregiver issues or client choice. Chapter 5 of the Long Term Care Manual for Case Management Services and protocols from the Challenging Cases Workgroup provide guidelines for appropriate activities and interventions.
9. It is recognized that even with a good service plan in place, the potential for a negative outcome exists. The protocol provides policy direction for definition of case management practice related to skin observation over pressure points.

10. Nursing Services resources will be used by HCS/DDD Social Workers and AAA Case Managers according to Chapter 24 of the LTC manual, or other nursing resource guidelines.

11. Training is an important component in decreasing the risk of skin breakdown over pressure points for our clients. This includes training for caregivers and case managers as well as educational materials for clients, their families, and caregivers.

## Skin Observation Protocols

### Observation Not Required

- 1) Client does not meet highest risk indicators
  - (a) **Document** all standard client assessment and service planning activities
- 2) Client has skin problem over pressure points and a non-professional is doing care.
  - i) When possible, on the same day, the HCS/AAA Nurse, or other contracting nursing resources will:
    - (a) **Review** the treatment being done with the caregiver and the client.
    - (b) **Document** what is being done and who authorized treatment.
    - (c) **Verify** by asking the caregiver that he/she is checking all pressure points.
    - (d) **Distribute** educational materials and prevention plans related to pressure points to caregiver and client (pictures or text).
    - (e) **Revise** service plan as needed.
    - (f) **Document** all activities
- 3) Client has a skin problem over pressure points and a professional is providing the care:
  - i) HCS/DDD Social Worker/Nurse or the AAA Case Manager or Nurse **verifies**:
    - (a) There is a treatment plan in place
    - (b) Client's skin has been seen by the Health Care Professional (HCP) responsible for treatment according to timeframes recommended in the treatment plan or within the last 7 days.
  - ii) HCS/DDD Social Worker/Nurse or the AAA Case Manager or Nurse **communicates** with the HCP, as soon as possible, but not to exceed 5 working days, to:
    - (a) **Verify** that all pressure points are being checked and discuss response to treatment.
    - (b) **Request** to be notified when client is discharged from care for pressure ulcers. At that time, the HCS/DDD Social Worker/Nurse or the AAA Case Manager consults with Nursing Services resources.
    - (c) **Document** all activities.
- 4) Client is cognitively intact and:
  - o Meets the highest risk indicators and
  - o Declines observation of skin over pressure points and
  - o HCS/DDD Social Worker/Nurse or the AAA Case Manager does not know if there is a problem
  - iii) **Probe** for reasons client doesn't want skin observed
  - iv) **Suggest** appropriate alternatives (such as asking if the client has checked their pressure points themselves or if the caregiver is reliable, have they checked) Use the color pictures included with the protocol as a resource to ask the client or caregiver regarding the presence of any of the pictured skin conditions or changes;
  - v) **Document** and
  - vi) **Refer** to HCS/AAA nurse or other contracting nursing resources for follow up;  
or

vii) **Contact** client's primary care provider as soon as possible, discuss skin concerns and document; or

**Advise** the client of skin care issues, educate and document; and

**Do not complete** skin observation. ,

viii) Document within CARE on the appropriate screen(s) the client has declined skin observation and follow CARE policies for client signature of Service Summary indicating client declination of skin observation. Discuss with supervisor.

### **Observation required**

Client meets highest risk indicators as identified by the skin observation protocol:

Client will be referred to HCS/AAA/DDD Nurse or other contracting nursing resources to complete the observation.

### **Steps to complete the observation**

- i) **Arrange** to have a third party present if you know in advance that there is a likelihood that you will need to observe the client's skin. Involve the client in determining who this third party should be when possible.
- ii) **Explain** what is involved in the skin observation to the client and ask permission.
- iii) **Tell** the client where the pressure points are
- iv) **Look** at the back of the head, both ears, shoulder blades, elbows, insides of the knees, "seat" bones, tailbone area, hips, sides of ankles and both heels.
- v) **Help** or have the caregiver help if the client needs to undress partially. Be sure that there is privacy for the client and the client remains covered except for the area being observed.
- vi) **Observe** for specific conditions - skin intact, persistent redness, abrasion, blister, shallow crater, deep crater, etc., as directed in CARE assessment using the skin problem screen and skin observation descriptions as a guide.
- vii) **If no skin problem is observed, document and revise** service plan to include prevention plan(s) as appropriate.
- viii) **If a skin problem is observed:**
  - (1) **Determine** if there are any health professionals involved with treatment of the client's skin problem or if any health professionals are aware of the problem.
  - (2) **Contact** any health professionals involved with treatment of the client's skin problem, within 2 working days, or
  - (3) **Contact** family rep if no health professionals involved or client is refusing treatment or HCP is not treating.
  - (4) **Document** all steps taken in the service episode record or progress note.

### **The skin observation may be delayed if the client meets the highest risk indicators and:**

- 1) The situation is unsafe and the personal safety of the HCS CNC, AAA/DDD Nurse, or other contracting nursing resources may be at risk because of threatening animals, sexually inappropriate behavior or threatening behaviors; or
- 2) Unable to observe skin because of soiling or unhygienic conditions and no caregiver present to assist or the client's physical condition makes it physically very difficult to observe skin (immobile, needs transfer or positioning assistance, client is in pain) or

client refuses to allow observation, has an unreliable provider and won't let anyone else in, and /or refuses services related to skin integrity over pressure points.

- i) **Anticipate** these barriers as much as possible and make arrangements prior to the visit to have a caregiver, assistant, or family member present to help client.
  - ii) **Discuss** other resources and approaches with supervisor within one working day and follow usual CM response times. Utilize collateral contacts for information and assistance.
  - iii) **Reschedule** observation within 2 working days.
  - iv) **Follow** usual CM timeframes per LTC Manual
  - v) **Refer** to APS if abuse, neglect or self neglect is suspected
  - vi) **Document** all of your activities including any arrangement you have made, discussions you have had or referrals you have made.
- 3) Client is cognitively intact; and
- o Declines skin observation over pressure points; and
  - o There is evidence of negative skin outcome (foul odor, staining on clothing over pressure points or other visible sign). **Determine and provide** any or all of the following activities appropriate to the client situation:
    - i) **Call 911**, if emergency medical care is required,
    - ii) **Identify** someone else to observe- for instance- the caregiver, a family member or person that client feels comfortable with
    - iii) **Refer immediately** to Nurse or Nursing Services resources for observation visit as soon as possible, if HCS/DDD Social Worker or AAA Case Manager is not a nurse.
    - iv) **Verify** and document that observation was done.
    - v) **Collect** collateral info re: skin problems over pressure points from health care providers, caregiver, family or other involved parties.
    - vi) **Educate** caregiver by going over section of the service plan that describes skin care over pressure points, including Prevention Plans for Skin Breakdown over Pressure Points within 5 working days.
    - vii) **Refer to** home health nurse or primary care provider within 2 working days
    - viii) **Refer to** APS or CRU as appropriate if negative skin outcome is believed to be the result of abuse or neglect, make referral same day as visit
    - ix) **Explore** other appropriate services such as residential placement, different caregiver, community clinic, or other community-based resources (discuss with supervisor).
    - x) **Discuss** with all involved parties' and come to consensus about concrete criteria about when or whether to terminate services, following the protocols established by the Challenging Cases Workgroup.
    - xi) **Document** all activities
    - xii) **Incorporate** recommendations of LTC Manual Chapter 5, Case Management, as well as the "Challenging Cases Workgroup" as appropriate. Client may be kept open to CM services, may use a (Personal Emergency Response Service) PERS unit and may be referred to CDMHP or the "A" team. Activities such as daily welfare checks by CM, family or other community members such as police, EMTs, or other identified gatekeepers.
- 4) Client is cognitively impaired (CPS score >3); and
- o Meets the highest risk indicators; and
  - o Declines skin observation once or mildly objects to the observation

- i) **Request** permission a second time using skilled interview and assessment techniques,
  - ii) **Be sure** that the client understands as much as possible what you are requesting.
  - iii) **Document** all activities
- 5) Client is cognitively impaired (CPS score > 3) and
  - o Meets highest risk indicators,
  - o Consistently refuses, and
  - o Skin condition over pressure points is unknown.
  - o Has an unreliable provider and won't let anyone else in, and /or
  - o Refuses services related to skin integrity over pressure points.
    - i) Refer to LTC Manual Chapter 5 Case Management and the Challenging Cases Protocol;
    - ii) **Refer** to and consult with supervisor and other services
      - (a) Offer alternative services or;
      - (b) Offer a different provider or;
      - (c) Residential placement or;
      - (d) Change in way services are delivered and;
    - iii) **Probe** to understand basis of refusal and
    - iv) **Refer** to APS if there are allegations of abuse, neglect or self-neglect.
    - v) **Refer** to 911, ER, or CDMHPs, if appropriate for involuntary treatment
    - vi) **Refer** for guardianship with AAG involvement, if appropriate.
    - vii) **Document** all activities
  - o Client meets highest risk indicators but observation not completed due to culture or gender
    - i) **Consult** with supervisor as soon as possible to find a reasonable solution. A reasonable solution is defined as timely, respecting of personal and professional boundaries, and has an end result that someone observes client's skin and documents what was done for client; and
    - ii) **Document** all activities.

## HIGHEST RISK INDICATORS FOR SKIN BREAKDOWN OVER PRESSURE POINTS

### Stand Alone Items

- Current Pressure Ulcer
- Quadriplegia
- Paraplegia
- Total Dependence in Bed Mobility
- Comatose or Persistent Vegetative State
- History of pressure ulcer within one year

### II. Combination of Elements

1. Bedfast and/or chairfast, and cognition problems.
2. Bedfast and/or chairfast, and incontinent of bladder or bowel.
3. Hemiplegia, and cognition problems, and incontinent of bladder or bowel.
4. Bedfast and /or chairfast, and Insulin Dependent Diabetes Mellitus (IDDM)

Bladder incontinence is defined as multiple daily episodes of the individual being wet, even with the use of appliances or programs used to manage this.

Bowel incontinence is defined as inadequate control all or almost all of the time, even with the use of appliances or programs to manage this.

Note: Cognitive impairment is defined by a score of 3 or higher on the Cognitive Performance Scale.