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Owner Amber Bowers:
Mgr Nursing Services
Area/Department Nursing
Applicability Munson Healthcare Systemwide
Tags Guideline

Inpatient Skin Assessment and Intervention Guidelines

Purpose

To provide a standard approach to skin assessments, interventions to prevent skin breakdown/pressure injuries, and treatment of skin variances.

Definitions

1. **Skin Variance:** is a deviation or unusual finding in skin (e.g. blister on right arm, multiple scattered bruises on bilateral lower extremities).
2. **Pressure Injury (PI):** is localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or another device. PI can present as intact skin or an open ulcer and may be painful. Skin integrity and PI development may be affected by microclimate, nutrition, friction and shear forces, co-morbidities, and condition of the tissue.
3. **Wound Ostomy Continence Registered Nurse (WOCN):** A specially trained registered nurse who provides clinical expertise in the areas of wound, ostomy, and continence care.
4. **"Second Set of Eyes":** a variation on the skin assessment when another licensed or unlicensed caregiver actively participates in the observation of the patient's skin to ensure all potential variances are assessed / documented.

Scope and Responsibilities

- A. Any licensed or unlicensed professional that participates in patient care has a responsibility to observe the patient's skin in role-related activities and intervene or notify the registered nurse (RN) of any observations in order to promote skin integrity.

- B. The nursing assistant shall report skin variances or changes observed during patient care activities and may support interventions delegated by the RN (eg., turning, weight redistribution, barrier cream application, etc.)
- C. Other disciplines such as physical therapy (PT), occupational therapy (OT), registered dietician, and/or respiratory therapy (RT) participate in similar assessment related to role specific patient care activities. They may provide role related interventions (eg., PT manages wound vac devices, RT supplies pressure reducing pads for respiratory care devices) and/or may collaborate with the RN to add interventions to the multidisciplinary care plan or to provide specific patient / support person education related to skin care or wound management.
- D. When present, the WOCN may:
 - 1. Validate assessed findings for present on admission (POA) or hospital-acquired PI.
 - 2. Stage, photograph and document the variance or wound.
 - 3. Recommend additional interventions to prevent additional breakdown.
 - 4. Assess and recommend treatment for more complex skin variances / wounds, according to professional standards.
 - 5. Assess existing ostomies and coordinate with department to ensure availability of supplies while patient is hospitalized.
 - 6. Assist with new ostomies for both in-patient and out-patient clients, where applicable.

Guideline

Assessment Standards

- A. All patients receive a skin assessment:
 - 1. Upon admission (within 24 hours)
 - 2. Every shift (minimally every 12 hours)
 - 3. Upon transfer from another unit
 - 4. Upon return from any procedural department when the patient is at risk for pressure injury
- B. At admission, a "**Second Set of Eyes**" is required on all patients (excluding obstetrical patients and newborn patients) to verify skin observations / findings
- C. All patients have a skin risk assessment (i.e. Braden, Braden-Q, Neonatal Skin Risk Assessment Scale [NSRAS]) completed at admission and every shift (minimally every 12 hours).
- D. In addition to a skin risk assessment, other factors may predispose a patient to pressure injury or skin breakdown and should also be incorporated into the individual plan of care including:
 - 1. Anticipated bedrest for over 24 hours
 - 2. Vasopressor therapy
 - 3. Sepsis or suspected sepsis

4. Mechanical ventilation
5. Compromised nutrition (low serum albumin)
6. Restraints
7. Dialysis
8. Procedures lasting 3 hours or more
9. Compromised tissue viability (severe bruising, edema, vascular deficiency, high doses of steroids, anticoagulation)
10. History of pressure injuries

Care Planning / Interventions / Documentation

- A. When risk areas are identified via the Braden Scale or other risk assessment tool, the RN selects individualized interventions for each subscale (i.e. sensory perception, moisture, activity, mobility, nutrition, friction/shear). The plan of care shall be based on the specific areas of risk, as well as the total risk assessment score, and other factors that may increase risk of pressure injury.
- B. Consult WOCN if available.
- C. Consider multidisciplinary collaboration or consultation.
- D. Document assessed findings. Refer to [Lippincott: Wound Assessment](#) for information on measuring wounds.
- E. Document interventions, including any patient refusals.
- F. If assessment or interventions are not clinically appropriate document the reason.
- G. Teach patient and family about risk for pressure injury and implemented interventions.

References

1. [LIPPINCOTT Skin Assessment: Comprehensive Head-to-Toe \(MUNSON\)](#)
2. [LIPPINCOTT Pressure injury prevention](#)
3. [quick-safety-25-update-3-21-22.pdf \(jointcommission.org\)](#)
4. [Lippincott: Wound Assessment](#)
5. [AHRQ Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care](#)

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	12/4/2025

CNO Council
Document Owner

Jennifer Standfest: CNO
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Services

12/2/2025
11/6/2025








Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards






No standards are associated with this document

COPY

PRODUCT NAME	Envella Air Fluidized Therapy Bed	VersaCare P500 Therapy Surface	Progressa Bed System	Compella Bariatric Bed	TotalCare Bariatric Plus Bed	Stryker Bed IsoTour	VersaCare	
SURFACE OPTION	Air Fluidized	Alternating air pressure redistribution	Pulmonary Surface with alternating air pressure redistribution	Low Air Loss with CLRT	Low Air Loss with CLRT and P&V Modules	Pressure redistribution gel mattress without the pump Low Air Loss Potential with Pump	VersaCare A.I.R. with nano Ag+ Pressure-relieving redistribution	
OWNED/RENTAL #	Rental P0819A or P0821A w/ Trapeze	Rental P3200DRENT03	Owned P008854	Rental P006746A or P006749A w/ Trapeze	Rental P1840RE300	Owned 3009 w/ Pump	Owned	
IMAGE								
PATIENT INDICATION	Pt Weight Capacity: 350 lbs Aids in the high risk treatment of advanced pressure injuries, flaps, grafts, burns, and lower trunk/leg wounds.	Pt Weight Capacity: 500lbs Aids in the prevention/treatment of pressure injuries.	Pt Weight Capacity: 70-500lbs Intended to be used to treat or prevent pulmonary or other complications associated with immobility or pressure injuries.	Pt Weight Capacity: 250-1,000lbs Intended use for patients within a weight range. Therapy support surface may prevent pulmonary complications or pressure injuries.	Pt Weight Capacity: 200-500lbs Intended to deliver comprehensive support to help mobilize patients of size.	Pt Weight Capacity: 550lbs Aids in the prevention/treatment of pressure injuries.	Pt Weight Capacity: 500lbs Intended use in multiple healthcare settings, standard bed.	
PRODUCT FEATURES	Standard Rental Features: Air Fluidized therapy provides superior performance for all major skin risks factors Weight-based pressure redistribution Optional Features: Patient helper trapeze	Standard Rental Features: Advanced Microclimate technology Integrated weight-based pressure redistribution surface Low Position Turn Assist, max inflate, comfort adjust, chair mode feature	Standard Features: Powered Air Surface: Synchronizes with frame when CLRT or Percussion and Vibration Therapy function is activated, weight based pressure redistribution, Advanced Microclimate technology eliminates excess heat and moisture Full chair position Low Position	Standard Rental Features: Low air loss with Turn Assist and CLRT Pressure redistribution Low position Optional Features: Patient helper trapeze	Standard Rental Features: Integrated weight-based pressure redistribution air surface with Advanced Microclimate Technology Low position Supports mobility protocols: CLRT, tilt table, full chair position Turn assist/Seat deflate	Standard Features: Pressure redistribution gel structure in 3 zones Microclimate management mattress TurTurn assist helps with turning, lifting, and offloading patients- up to 30 degrees turn angle Optional Features: IsoTour pump is designed to convert the surface to low air loss automatically and allows for TruTurn easily	Standard Features: Helps with common wound care functions like Turn Assist and Max inflate Low Chair position Interchangeable therapy surfaces on bed frame	
MANUFACTURER INSTRUCTIONS	Envella® Air Fluidized Therapy System Instructions	P500 Therapy Surface Hillrom	Progressa® Bed Instructions for Use	Hillrom Compella	TotalCare Bariatric Plus Hospital Bed In-Service Tools Hillrom	IsoTour® Pump	Hillrom VersaCare Bed	
KEY							IsoTour Gel Pressure Mattress Stryker	





*Turn Assist feature can help reduce the physical strain on the caregivers when providing care. This does not eliminate the need for turning and repositioning patients, including on the specialty beds.

BARIATRIC
LOW BED
WOUND
CRITICAL CARE

PRODUCT NAME	ComfortGlide Foam Wedges	Z-Flo Fluidized Positioner	DJO Podous "Prafo" Boot	HeelMedix FootCheck Heel Protectors	ROHO Chair Cushions- Mid Profile
MANUFACTURER/ORDER INFORMATION	Medline Product Item #90004 (pair of 2) #90005 (bariatric firm)	NMSA NMSA Item NMSA item # 75720 (12in x 20in) NMSA item #75719 (25in x 36in)	NMSA item #29091	Medline Product NMSA item #27134	NMSA item# 89142
IMAGE					
PATIENT INDICATION	Provide an effective solution for offloading pressure at high-risk points. Keeping patients in the 30-degree tilt position.	Used to help offload bony prominences while maintaining neutral body alignment.	Helps treat lower extremity disorders associated with trauma including pressure necrosis, ankle contractures, and post-op hip abduction or rotation	Designed to completely off-load vulnerable heels	Maximum pressure relief cushion, helps to prevent skin breakdown, optimal seating environment for individuals with skin/soft tissue integrity issues. Decreasing friction and shear.
PRODUCT FEATURES	Nonskid cover can be easily cleaned Reuseable	Benefits include: won't lose shape, conforms to and supports patient, molds to anatomic shape Suitable for use in adult and pediatrics Single Patient Use	Not intended as an ambulatory product, other than short distances Single Patient Use	Advanced Pressure Redistribution Level Single Patient Use	Washable, repairable, and ventilated. Reuseable
MANUFACTURER INSTRUCTIONS	Comfort Glide Wedge	Z flo Instructions	Podous Boot Application	HeelMedix FootCheck HeelMedix Advanced	ROHO® Inflation: Set up and check in five easy steps! ROHO How to adjust your cushion

Moisture Management Guidelines

- Cleanse affected area with pH balanced cleanser and soft cloth BID and PRN. Pat dry.
- Utilize a microclimate pad while in bed. **AVOID** briefs / diapers.
- Antimicrobial silver impregnated cloth (e.g. InterDry) may be helpful to control moisture in skin folds (e.g. pannus, under breasts)
- Select and apply appropriate barrier cream(s), based on clinical assessment.
- It may be appropriate to use more than one cream to treat adjacent skin areas with different clinical presentation (e.g. Antifungal for yeast rash, Desitin™ for severe skin breakdown)

Barrier Cream	Triad® Hydrophilic Wound Dressing Past Zinc Oxide, cellulose gum, Dimethicone, petrolatum	Medline Remedy® Prevent 24% Silicone Blend 12.5% Dimethicone	Diaper Rash™ or Desitin™ 40% Zinc Oxide	Medline Remedy® Protect 57% White Petrolatum 17% Zinc Oxide
				
Clinical Presentation	Wounds on irregular surfaces Broken skin in the presence of incontinence Maceration of the periwound skin	Occasional urinary and fecal incontinence Skin reddened but no breakdown Chapped or cracked fragile skin	Frequent urinary and fecal incontinence Severe skin redness and skin breakdown (including pressure injuries)	Relief for local itching/discomfort in perianal area For skin exposed to prolonged moisture Protect torn or exposed skin
Application and Removal	Apply thin layer to wound		Apply thin layer over affected area only	Apply to clean skin up to six times per day

Moisture Management Guidelines

	Use pH-balanced wound cleanser and gently wipe clean	Apply cream to clean intact area after every incontinent episode	Remove top layer only when necessary, using foam cleanser	Use pH-balanced skin cleaner and gently wipe clean
Special Considerations	Contraindications: Third-degree burns of infected wounds	Avoid use on mucous membranes, deep injury or puncture wounds, around eyes	Avoid use on areas of dry skin	Avoid contact with eyes or mucous membranes
How to get	Floor stock, any team member can apply	Floor stock, any team member can apply	Provider to order Comes from pharmacy	Floor stock, any team member can apply