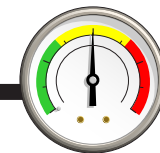


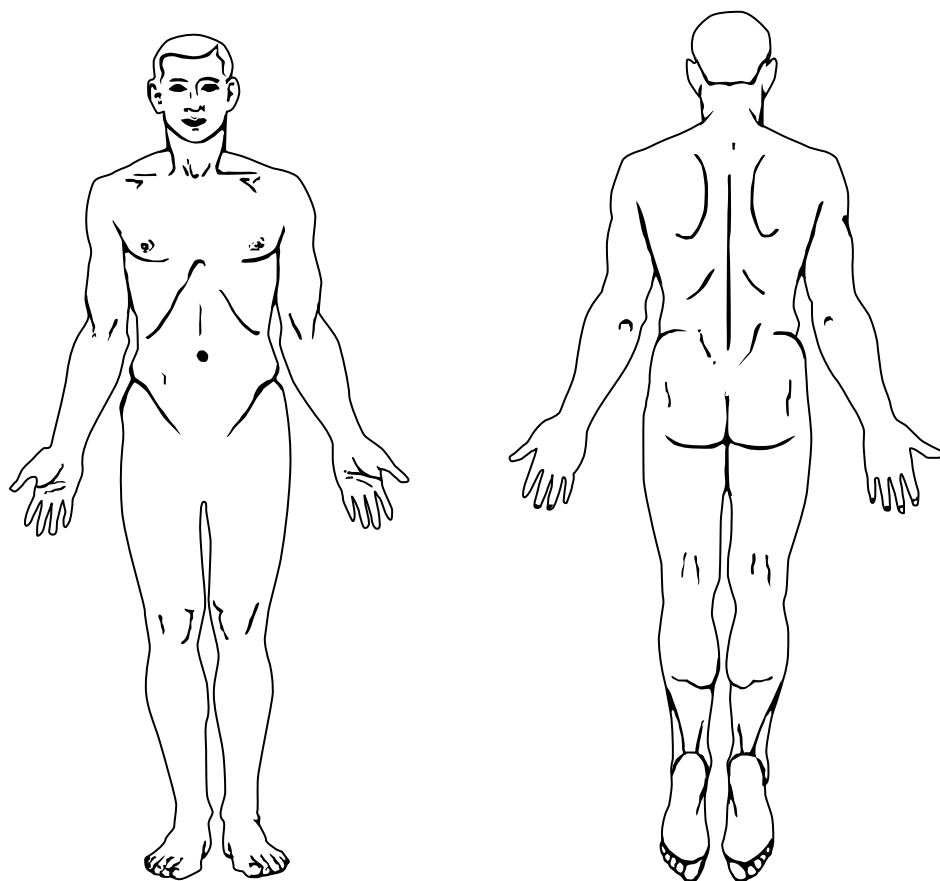
Licensed Nurse Weekly Skin Assessment



Resident: _____ Date: _____ Room #: _____

This form should be completed weekly on all residents per facility policy. Any areas of skin requiring treatment should have a thorough record of documentation in addition to this form located elsewhere in the chart per facility protocol. Check "Yes" or "No" if the item reflects the resident's assessment. If the answer is "yes" to 3 or more of the items listed below, consider implementation of the "Skin Tear Prevention Protocol." Review the care plan to ensure skin care is included as necessary.

If any questions are answered "yes," indicate location on body outline with number of question.



Weekly Skin Assessment		Yes	No
1	Any reddened areas that remain after 30 minutes of pressure reduction? <i>Comments:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
2	Any rashes? <i>Comments:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
3	Any bruises? <i>Comments:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
4	Any open lesions, cuts, lacerations, or skin tears? (Indicate even if being treated.) <i>Comments:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
5	Any blisters? <i>Comments:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
6	Any open ulcers (indicate even if being treated.) <i>Comments:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
7	Excessively dry or flaky skin? <i>Comments:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
8	Any edema? <i>Location:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>

Licensed Nurse Signature: _____ Date: _____

Document available at www.primaris.org

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