

skin assessment documentation sample

skin assessment documentation sample is an essential resource for healthcare professionals seeking to ensure accurate, consistent, and comprehensive recording of patient skin assessments. Proper skin documentation supports early detection of pressure injuries, wounds, or skin changes, ultimately improving patient outcomes and facilitating communication among care teams. In this article, we will provide a detailed overview of skin assessment documentation, explore best practices, and present a practical skin assessment documentation sample. We will also discuss critical elements to include in your documentation, common tools used in clinical practice, and tips for enhancing the quality of your records. Whether you are a nurse, physician, or allied health professional, understanding how to document a thorough skin assessment is vital for delivering high-quality care and meeting regulatory standards. Read on to discover a comprehensive guide that will help you master the process of skin assessment documentation and apply these insights in your clinical setting.

- Understanding the Importance of Skin Assessment Documentation
- Key Elements of a Comprehensive Skin Assessment
- Common Tools and Scales Used in Skin Assessment
- Best Practices for Skin Assessment Documentation
- Skin Assessment Documentation Sample Explained
- Tips to Improve Skin Assessment Documentation Quality
- Common Errors in Skin Assessment Documentation
- Summary of Essential Takeaways

Understanding the Importance of Skin Assessment Documentation

Accurate skin assessment documentation is fundamental in clinical settings to ensure continuity of care and early intervention for skin-related issues. Comprehensive documentation enables healthcare providers to monitor changes over time, evaluate treatment efficacy, and comply with legal and accreditation requirements. The process also reduces the risk of miscommunication between care team members and supports defensible medical records in the event of audits or litigation. By using a standardized approach, clinicians can identify pressure injuries, infections, or other dermatological concerns more effectively, ensuring timely and appropriate interventions.

Key Elements of a Comprehensive Skin Assessment

A detailed skin assessment documentation sample should include specific information that allows for a clear and complete understanding of the patient's skin integrity. Incorporating these key elements ensures that no critical data is missed and supports the delivery of effective care.

Patient Demographics and History

Documenting basic patient information is the foundation of any skin assessment. This typically includes patient name, age, gender, medical history, and relevant risk factors such as immobility, incontinence, or chronic diseases.

Overall Skin Appearance

Accurately describing the general condition of the skin provides context for specific findings. Noting color, texture, temperature, moisture, and turgor helps establish a baseline for future comparisons.

Detailed Lesion or Wound Descriptions

When lesions, wounds, or pressure injuries are present, documentation should specify location, size, depth, color, exudate, odor, and surrounding tissue condition. This level of detail is crucial for monitoring progress and adjusting treatments.

Pain Assessment

Recording the presence and intensity of pain, as well as any factors that exacerbate or relieve it, is an important aspect of skin assessment documentation and guides appropriate interventions.

Risk Assessment Scores

Including risk assessment tool scores, such as the Braden Scale, identifies patients at higher risk for skin breakdown and informs preventive strategies.

- Patient identifiers (name, date of birth, medical record number)

- Skin color, texture, temperature, and moisture
- Location and description of any wounds or lesions
- Pain level and characteristics
- Risk assessment score and date
- Interventions initiated and patient response
- Signature and credentials of the assessor

Common Tools and Scales Used in Skin Assessment

Utilizing standardized tools and scales in skin assessment documentation ensures consistency and objectivity. These instruments help quantify risk, guide clinical decision-making, and facilitate communication across care settings.

Braden Scale

The Braden Scale is widely used for predicting pressure ulcer risk by assessing sensory perception, moisture, activity, mobility, nutrition, and friction/shear. Scores help prioritize preventive measures for high-risk patients.

Norton Scale

The Norton Scale evaluates physical condition, mental state, activity, mobility, and incontinence. Lower scores indicate higher risk of pressure injury development.

Waterlow Score

The Waterlow Score incorporates factors such as build/weight, skin type, age, continence, and mobility to identify patients at risk. It is especially common in the UK and other international settings.

Best Practices for Skin Assessment Documentation

Effective skin assessment documentation requires a systematic approach that adheres to clinical standards and legal requirements. By following best practices, healthcare professionals can enhance the accuracy and clarity of their records, leading to improved patient care.

Use Objective and Descriptive Language

Avoid vague terms; instead, use precise descriptors for color, size, shape, and texture. For example, document "2 cm x 1 cm stage II pressure injury with pink, moist wound bed and no exudate" rather than "small sore."

Document Findings Promptly

Timely documentation ensures that assessments reflect the patient's current status and reduces the risk of omissions or inaccuracies.

Include Patient and Family Input

Patient or family-reported symptoms or concerns can provide valuable context and should be included to create a holistic record.

Maintain Confidentiality and Compliance

Ensure all documentation complies with privacy regulations and institutional policies to protect patient information.

Skin Assessment Documentation Sample Explained

A well-structured skin assessment documentation sample provides a template for recording all essential information in a clear and organized manner. Below is an example of how to document a skin assessment in a clinical setting:

- **Patient Name:** John Doe

- **Date of Assessment:** 2024-06-20
- **Assessor:** Jane Smith, RN
- **Medical History:** Type 2 Diabetes, limited mobility
- **Overall Skin Appearance:** Skin warm, dry, intact. Color pale pink. Turgor normal. No generalized edema.
- **Wound/Lesion Description:** 2 cm x 1 cm stage II pressure injury on left heel. Wound bed pink and moist. No exudate. Surrounding skin erythematous but intact. No odor.
- **Pain Assessment:** Patient reports mild tenderness at wound site, rates pain 3/10.
- **Risk Assessment:** Braden Score = 14 (moderate risk)
- **Interventions:** Pressure-relieving mattress initiated. Wound cleaned with saline, hydrocolloid dressing applied. Patient repositioned every 2 hours.
- **Patient/Family Education:** Instructed on pressure injury prevention and signs of infection.
- **Signature:** Jane Smith, RN

This sample demonstrates the level of detail needed for effective skin assessment documentation. It covers patient identification, assessment findings, risk evaluation, interventions, education, and professional authentication.

Tips to Improve Skin Assessment Documentation Quality

Enhancing the quality of skin assessment documentation involves a commitment to accuracy, consistency, and ongoing education. The following tips support excellence in clinical documentation:

- Follow a systematic head-to-toe approach to avoid missing areas of concern.
- Use anatomical landmarks to describe wound or lesion locations precisely.
- Incorporate photographs when permitted, with patient consent.
- Update documentation regularly to reflect changes in skin condition or interventions.

- Participate in ongoing training on documentation standards and wound care best practices.

Common Errors in Skin Assessment Documentation

Despite best efforts, certain documentation errors can compromise patient safety and record integrity. Recognizing and addressing these mistakes is crucial for quality assurance.

- Using non-specific language or abbreviations that may be misinterpreted
- Failing to document changes in wounds or skin findings over time
- Omitting patient-reported symptoms or input
- Neglecting to record risk assessment scores or interventions taken
- Forgetting to sign or authenticate the documentation

Summary of Essential Takeaways

Skin assessment documentation is a vital process that underpins safe, effective patient care. By incorporating comprehensive information, using standardized tools, and following best practices, healthcare professionals can ensure their documentation meets regulatory and clinical expectations. Utilizing a skin assessment documentation sample helps streamline the process and guarantees that all critical elements are included for optimal patient outcomes.

Q: What should be included in a skin assessment documentation sample?

A: A skin assessment documentation sample should include patient demographics, overall skin appearance, detailed descriptions of any wounds or lesions, pain assessment, risk assessment scores, interventions performed, patient or family education, and the signature of the healthcare provider.

Q: Why is accurate skin assessment documentation important in healthcare?

A: Accurate skin assessment documentation is essential for monitoring patient progress, identifying early signs of skin breakdown or infection, guiding treatment decisions, and ensuring legal and regulatory compliance.

Q: Which tools are commonly used in skin assessment documentation?

A: Commonly used tools include the Braden Scale, Norton Scale, and Waterlow Score, which assess risk factors for pressure injuries and help guide preventive interventions.

Q: How often should skin assessments be documented?

A: The frequency of skin assessment documentation depends on patient risk factors and institutional policy, but it is typically performed upon admission, daily, and whenever there is a change in skin condition.

Q: What common errors should be avoided in skin assessment documentation?

A: Common errors include vague descriptions, failure to update documentation, omitting patient-reported symptoms, neglecting risk assessment scores, and missing signatures or credentials.

Q: How can the quality of skin assessment documentation be improved?

A: Quality can be improved by using a systematic approach, being specific and objective, regularly updating records, incorporating standardized tools, and participating in ongoing training.

Q: What is the significance of including patient and family education in documentation?

A: Documenting patient and family education demonstrates that preventive strategies and symptom recognition have been discussed, supporting patient involvement and helping to meet accreditation standards.

Q: Can photographs be included in skin assessment

documentation?

A: Yes, photographs can enhance documentation accuracy, provided patient consent is obtained and institutional policies are followed regarding confidentiality and record keeping.

Q: How does a risk assessment score influence patient care?

A: Risk assessment scores help identify patients at higher risk for skin breakdown, guiding the implementation of targeted preventive measures and resource allocation.

Q: What are the legal implications of incomplete skin assessment documentation?

A: Incomplete documentation can result in gaps in care, increased risk of adverse outcomes, and potential legal liability for healthcare providers and institutions.

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Skin Assessment Documentation Sample: A Comprehensive Guide for Professionals

Are you a healthcare professional struggling to create accurate and thorough skin assessment documentation? Accurate documentation is crucial for effective patient care, avoiding legal issues, and ensuring smooth transitions between healthcare providers. This comprehensive guide provides a sample skin assessment documentation template, explains its key components, and offers valuable tips to ensure your documentation is both comprehensive and compliant. We'll cover everything you need to know to confidently document skin assessments, improving patient outcomes and minimizing potential risks.

Understanding the Importance of Detailed Skin Assessment Documentation

Accurate skin assessment documentation is not just about ticking boxes; it's a critical aspect of holistic patient care. It forms the foundation for:

Early Detection of Issues: Detailed records allow for the early identification of pressure ulcers, skin infections, allergic reactions, and other dermatological conditions. Early detection enables timely intervention and improved treatment outcomes.

Effective Treatment Planning: Comprehensive documentation provides the necessary information for tailoring treatment plans, monitoring progress, and adjusting strategies as needed.

Legal Protection: Meticulously documented assessments protect healthcare providers from potential liability by providing clear evidence of care provided and any identified issues.

Improved Communication: Well-structured documentation facilitates seamless communication between healthcare professionals involved in the patient's care, ensuring continuity and consistency of treatment.

Skin Assessment Documentation Sample: A Template

This sample skin assessment documentation template provides a framework. Remember to adapt it to your specific facility's requirements and the individual needs of your patient.

Patient Name: [Patient Name]

Medical Record Number: [Medical Record Number]

Date of Assessment: [Date]

Time of Assessment: [Time]

Assessor: [Your Name/Designation]

I. Patient History:

Relevant Medical History: [List any relevant medical conditions, such as diabetes, allergies, or history of skin problems]

Medications: [List all medications the patient is currently taking]

Allergies: [List any known allergies, including medication and topical allergies]

Recent Procedures/Treatments: [Note any recent procedures or treatments that may affect the skin]

II. Assessment Findings:

Overall Skin Appearance: [e.g., pale, flushed, cyanotic, jaundiced, dry, moist, warm, cool]

Skin Turgor: [e.g., normal, decreased (tenting), increased]

Skin Temperature: [e.g., warm, cool, hot]

Skin Moisture: [e.g., dry, moist, excessively moist]

Skin Integrity: [Describe any lesions, wounds, or abnormalities. Include location, size, depth, color, drainage (if any), and surrounding skin characteristics. Use standardized terminology (e.g., Braden Scale for pressure ulcer risk assessment).] Example: "2cm x 1cm erythematous area on left heel, non-blanchable, suspected stage I pressure ulcer."

Presence of Rashes, Lesions, or Wounds: [Detailed description of each lesion, including location, size, shape, color, texture, and any other relevant characteristics. Include photographs if appropriate.]

Hair and Nails: [Note any abnormalities in hair or nail growth, texture, or color.]

III. Interventions:

[Describe any interventions undertaken, such as wound care, medication application, or recommendations for further evaluation.]

IV. Plan:

[Outline the plan of care, including frequency of assessments, interventions, and follow-up plans.]

V. Signatures and Dates:

Assessor Signature: _____

Date: _____

Tips for Effective Skin Assessment Documentation

Use Clear and Concise Language: Avoid medical jargon that may not be understood by other healthcare professionals.

Be Objective: Focus on observable facts rather than subjective opinions.

Use Standardized Terminology: Employ consistent terminology for describing skin conditions and lesions.

Include Photographs: When appropriate, include clear and well-labeled photographs to supplement written descriptions.

Maintain Regular Updates: Document all subsequent assessments and any changes in the patient's skin condition.

Follow Facility Policies: Adhere to your facility's specific guidelines and procedures for documentation.

Conclusion

Accurate and thorough skin assessment documentation is an essential component of high-quality patient care. By utilizing a well-structured template, adhering to best practices, and consistently updating records, healthcare professionals can significantly improve patient outcomes and mitigate

potential risks. The sample provided above serves as a starting point; always remember to adapt it to your specific needs and institutional policies.

FAQs

1. What is the Braden Scale and why is it important to include it in my documentation? The Braden Scale is a widely used tool for assessing a patient's risk of developing pressure ulcers. Including the score in your documentation provides objective data to support your assessment and treatment plan.
2. What kind of photographs should I include? Clear, well-lit, close-up photographs that accurately depict the size, shape, color, and texture of any lesions or wounds are ideal. Ensure you have the proper consent from the patient or their guardian.
3. What should I do if I discover a new skin lesion during an assessment? Immediately document the lesion's details, notify the appropriate healthcare professional, and follow your facility's protocols for managing new skin lesions.
4. How often should I perform skin assessments? The frequency of skin assessments depends on the patient's risk factors and overall condition. Patients at high risk may require daily assessments, while those at lower risk may require less frequent evaluations.
5. Are there any legal implications for inadequate skin assessment documentation? Yes, inadequate documentation can lead to legal consequences, including malpractice lawsuits. Thorough and accurate documentation is crucial for protecting healthcare professionals from legal liability.

skin assessment documentation sample: *Health Assessment in Nursing* Janet Weber, Jane Kelley, 2009-10-01 Now in its Fourth Edition, *Health Assessment in Nursing* is a colorful, user-friendly introductory level health assessment text for RN-level students. Targeted to ADN and BSN programs, this text presumes no prior knowledge of health assessment and is part of a suite that includes *Lab Manual to Accompany Health Assessment in Nursing*, *Nurses' Handbook of Health Assessment*, and *Weber & Kelley's Interactive Nursing Assessment*. For this edition, the COLDSPA mnemonic, which guides students through investigation of symptoms, has been revised to show specific applications to content in each chapter. A sample application of COLDSPA is presented at the beginning of each chapter's Nursing History section, and another accompanies each case study. The Frail Elderly chapter has been streamlined, with a stronger focus on the normal variations associated with assessment of elderly clients. Includes DVD-ROM.

skin assessment documentation sample: *Pocket Companion for Physical Examination and Health Assessment* Carolyn Jarvis, PhD Apn Cnp, 2015-03-30 Take this nursing handbook into the clinical setting! *Pocket Companion for Physical Examination & Health Assessment*, 7th Edition makes it fast and easy to look up essential assessment skills and techniques. You'll conduct more effective exams by referring to summaries of examination steps, normal versus abnormal findings, lifespan and multicultural considerations, and over 250 full-color photos and illustrations. Written by well-known educator and clinician Carolyn Jarvis, this handbook is a perfect clinical tool whether you're a beginner who is learning assessment skills or a practitioner who needs a portable reference! Convenient two-column format makes it easier to access, learn, and understand key physical examination skills and findings. More than 250 full-color illustrations demonstrate

examination skills, underlying anatomy and physiology, and normal and abnormal findings. Color-coded design helps you easily locate the information you need, dividing each body system chapter into major sections (anatomy, subjective data, objective data, and abnormal findings). Abnormal findings tables help you recognize, sort, and describe key abnormal findings. Summary checklists offer reviews of key examination steps for quick reference. Developmental Competence sections highlight content specific to infants, children, adolescents, pregnant women, and older adults. Spanish-language translation chart helps you improve communication with Hispanic patients during the physical examination. Cultural Competence sections provide a context for care of multicultural patient groups. NEW evidence-based guidelines reflect a focus on conducting the most effective, qualitative exams. NEW content on the Electronic Health Record, charting, and narrative recording includes examples of how to document assessment findings. NEW photos of normal and abnormal findings show the nose, mouth, throat, thorax, and pediatric assessment, including developmental and cultural variations.

skin assessment documentation sample: Fundamentals of Nursing & Midwifery Helen Hall, Paul Glew, Johanna Rhodes, 2022-01-03 A trusted person-centred resource to start you on the path to professional success Fundamentals of Nursing and Midwifery is a popular foundational nursing text specifically developed for Australian and New Zealand students. This comprehensive resource provides a detailed overview of key information with person-centred care highlighted throughout to focus on the individualistic, interactive and holistic nature of nursing and midwifery practice. It uses accessible language that introduces students to the 'why' as well as the 'how' of nursing and midwifery. It focuses not only on a person's physical healthcare needs, but also on the intellectual, emotional, sociocultural and spiritual aspects of care. In this way, students learn to be holistic health care professionals while acquiring the foundational knowledge, procedures and skills required for successful nursing or midwifery practice.

skin assessment documentation sample: Physical Examination and Health Assessment *E-Book* Carolyn Jarvis, 2019-01-07 With an easy-to-follow approach and unmatched learning support, Jarvis's Physical Examination and Health Assessment, 8th Edition is the most authoritative, complete, and easily implemented solution for health assessment in nursing. This tightly integrated learning package continues to center on Carolyn Jarvis's trademark clear, logical, and holistic approach to physical examination and health assessment across the patient lifespan. It's packed with vivid illustrations, step-by-step guidance and evidence-based content to provide a complete approach to health assessment skills and physical examination. With a fresh focus on today's need-to-know information, the 8th edition integrates QSEN and interprofessional collaboration, features enhanced inclusion of LGBTQ considerations, includes a new standalone Vital Signs chapter, and provides enhanced EHR and documentation content. - The most trusted name in health assessment for nurses, now in its 8th edition! - A clear, conversational, step-by-step, evidence-based approach to physical examination and health assessment of patients throughout the lifespan. - A consistent format from chapter to chapter features sections on Structure and Function, Subjective Data, Objective Data, Documentation and Critical Thinking, and Abnormal Findings to help you learn to assess systematically. - UPDATED! An unsurpassed collection of more than 1,100 full-color illustrations has been updated to vividly showcase anatomy and physiology, examination techniques, and abnormal findings. - Enhanced content on the electronic health record, charting, and narrative recording exemplify how to document assessment findings using state-of-the-art systems with time-tested thoroughness. - Engaging learning resources include assessment video clips; NCLEX® Exam review questions; case studies with critical thinking activities; audio clips of heart, lung, and abdominal sounds; assessment checklists, and much more. - Promoting a Healthy Lifestyle boxes present opportunities for patient teaching and health promotion while performing the health assessment. - Developmental Competence sections highlight content specific to infants, children, adolescents, pregnant women, and older adults. - Culture and Genetics sections include information on biocultural and transcultural variations in an increasingly diverse patient population. - NEW! Standalone Vital Signs chapter and refocused nutrition content include an expanded emphasis on

the national epidemic of obesity. - NEW! Enhanced integration of QSEN and interprofessional collaboration emphasize how to ensure patient safety during the physical exam and how to collaborate with other health professionals to promote optimal health. - NEW! Enhanced inclusion of LGBTQ issues and revamped and refocused Cultural Assessment chapter equip you with the skills to practice with greater sensitivity and inclusivity. - NEW! Health Promotion and Patient Teaching sections underscore the unique role of nurses (especially advanced practice nurses) in health promotion.

skin assessment documentation sample: Physical Examination and Health Assessment □

Carolyn Jarvis, 2015-03-09 With an easy-to-read approach and unmatched learning resources, *Physical Examination & Health Assessment*, 7th Edition offers a clear, logical, and holistic approach to physical exams across the lifespan. A total of 1,200 illustrations, checklists of key exam steps, and practical insights ensure that you learn all the physical exam skills you need to know. Written by Carolyn Jarvis, an experienced educator and clinician, this gold standard in physical examination reflects what is going on in nursing today with coverage of emerging trends and the latest on evidence-based practice. It's easy to see why this text is, far and away, #1 in this field! A clear, logical, and streamlined approach simplifies content and helps you learn to perform the complete health assessment: The conversational, easy-to-understand writing style makes learning easier. A two-column format distinguishes normal findings from abnormal findings, and uses step-by-step photos to clarify examination techniques and expected findings. 1,200 full-color illustrations present anatomy and physiology, examination techniques, and abnormal findings. Abnormal findings tables include more than 300 pathophysiology photos to help in recognizing, sorting, and describing abnormalities. Comprehensive coverage reflects the realities of today's nursing practice: NEW content on the Electronic Health Record, charting, and narrative recording provides examples of how to document assessment findings. 150 NEW normal and abnormal examination photos for the nose, mouth, throat, thorax, and pediatric assessment show findings that are unexpected or that require referral for follow-up care, with cultural diversity and developmental variations. UPDATED evidence-based practice content is highlighted and reflects a focus on conducting the most effective, accurate examinations. UPDATED case studies provide opportunities to apply your knowledge and develop your analytical skills. Checklists for use in RN-to-BSN completion programs provide a refresher for seasoned nurses returning to the classroom. A holistic approach to assessment accommodates the diverse types of patients that you will encounter in the real world: Documentation and Critical Thinking sections provide real-world clinical examples of specific patients and how to record assessment findings in the patient's chart, using the SOAP format. Promoting a Healthy Lifestyle boxes enable patient teaching and health promotion while performing the health assessment, and now address the key concept of prevention. Developmental Competence sections provide age-specific assessment techniques for infants, children, adolescents, pregnant women, and older adults. Culture and Genetics sections include biocultural and transcultural information on an increasingly diverse patient population. Spanish-language translations highlight important phrases for improved data gathering and communication during the physical examination with Spanish-speaking patients.

skin assessment documentation sample: Patient Safety and Quality Ronda Hughes, 2008 Nurses play a vital role in improving the safety and quality of patient care -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. (AHRQ Publication No. 08-0043). - online AHRQ blurb, <http://www.ahrq.gov/qual/nursesfdbk/>

skin assessment documentation sample: Pocket Companion for Physical Examination and Health Assessment - E-Book Carolyn Jarvis, 2018-12-27 - NEW! Updated content throughout

corresponds to the 8th edition of the Jarvis textbook, and incorporates the latest evidence-based assessment guidelines. - NEW! Enhanced Quality and Safety Education for Nurses (QSEN) content throughout text emphasizes the patient safety competency. - NEW! Health Promotion and Patient Teaching sections underscores the unique role of nurses (especially advanced practice nurses) in health promotion. - NEW! Improved look-and-feel of selected illustrations developed for the Jarvis textbook. - NEW! Updated Documentation sections with EHR integration reflect the types of documentation that nurses will enter into electronic health records (EHRs or EMRs).

skin assessment documentation sample: Kozier & Erb's Fundamentals of Nursing Australian Edition Audry Berman, Shirlee J. Snyder, Barbara Kozier, Glenora Lea Erb, Tracy Levett-Jones, Trudy Dwyer, Majella Hales, Nichole Harvey, Lorna Moxham, Tanya Park, Barbara Parker, Kerry Reid-Searl, David Stanley, 2014-12-01 Kozier and Erb's Fundamentals of Nursing prepares students for practice in a range of diverse clinical settings and help them understand what it means to be a competent professional nurse in the twenty-first century. This third Australian edition has once again undergone a rigorous review and writing process. Contemporary changes in the regulation of nursing are reflected in the chapters and the third edition continues to focus on the three core philosophies: Person-centred care, critical thinking and clinical reasoning and cultural safety. Students will develop the knowledge, critical thinking and clinical reasoning skills to deliver care for their patients in ways that signify respect, acceptance, empathy, connectedness, cultural sensitivity and genuine concern.

skin assessment documentation sample: Nursing Interventions & Clinical Skills - E-Book Anne G. Perry, Patricia A. Potter, Wendy R. Ostendorf, 2015-01-08 Master nursing skills with this guide from the respected Perry, Potter & Ostendorf author team! The concise coverage in Nursing Interventions & Clinical Skills, 6th Edition makes it easy to master the clinical skills required in everyday nursing practice. Clear guidelines address 159 basic, intermediate, and advanced skills — from measuring body temperature to insertion of a peripheral intravenous device — and step-by-step instructions emphasize the use of evidence-based concepts to improve patient safety and outcomes. Its friendly, easy-to-read writing style includes a streamlined format and an Evolve companion website with review questions and handy checklists for each skill. - Coverage of 159 skills and interventions addresses basic, intermediate, and advanced skills you'll use every day in practice. - UNIQUE! Using Evidence in Nursing Practice chapter provides the information needed to use evidence-based practice to solve clinical problems. - Safe Patient Care Alerts highlight unusual risks in performing skills, so you can plan ahead at each step of nursing care. - Delegation & Collaboration guidelines help you make decisions in whether to delegate a skill to unlicensed assistive personnel, and indicates what key information must be shared. - Special Considerations indicate additional risks or accommodations you may face when caring for pediatric or geriatric patients, and patients in home care settings. - Documentation guidelines include samples of nurses' notes showing what should be reported and recorded after performing skills. - A consistent format for nursing skills makes it easier to perform skills, always including Assessment, Planning, Implementation, and Evaluation. - A Glove icon identifies procedures in which clean gloves should be worn or gloves should be changed in order to minimize the risk of infection. - Media resources include skills performance checklists on the Evolve companion website and related lessons, videos, and interactive exercises on Nursing Skills Online. - NEW coverage of evidence-based techniques to improve patient safety and outcomes includes the concept of care bundles, structured practices that have been proven to improve the quality of care, and teach-back, a new step that shows how you can evaluate your success in patient teaching. - NEW! Coverage of HCAHPS (Hospital Care Quality Information from the Consumer Perspective) introduces a concept now widely used to evaluate hospitals across the country. - NEW! Teach-Back step shows how to evaluate the success of patient teaching, so you can be sure that the patient has mastered a task or consider trying additional teaching methods. - NEW! Updated 2012 Infusion Nurses Society standards are incorporated for administering IVs, as well as other changes in evidence-based practice. - NEW topics include communication with cognitively impaired patients, discharge planning and transitional care, and

compassion fatigue for professional and family caregivers.

skin assessment documentation sample: Fundamentals of Nursing Care Marti A Burton, Linda J May Ludwig, 2014-10-10 Take a fresh, new approach to nursing fundamentals that teaches students how to think, learn, and do while they make the 'connections' each step of the way.

skin assessment documentation sample: Emergency , 2006 Emergency Medical Technician

skin assessment documentation sample: Study Guide to Accompany Advanced Pediatric Assessment Ellen M. Chiocca, PhD, APRN, CPNP-PC, 2019-08-30 The only certification study guide to focus on advanced infant and child health assessment This is the only study guide available focusing specifically on the specialized knowledge and skills required to conduct the pediatric health assessment. Designed to accompany the text Advanced Pediatric Assessment, it reinforces essential content through case studies and multiple choice Q&As that mirror the Pediatric Nurse Practitioner Certification Exam format. The third edition includes new critical thinking exercises, case studies, and certification-style Q&As. It delivers a completely new chapter that covers clinical decision-making, formulating differential diagnoses, and evidence-based practice. It also provides SOAP notes for the well and abnormal exams. The third edition continues to deliver essential practice items for all aspects of the exam, along with sample documentation and a space where students can practice their own subjective and objective findings. In addition, Anatomic Labeling Exercises reinforce knowledge essential to the APN role. Each chapter is formatted systematically for ease of use and includes chapter overview, learning objectives, essential terminology, case studies, the well child, the ill child/child with problem, multiple choice questions mirroring the exam format, SOAP notes for well and abnormal exams, and answers. New to the Third Edition: Includes new critical thinking exercises, case studies, and certification-style exam questions Delivers completely new chapter addressing clinical decision making, formulating differential diagnoses, and evidence-based practice Provides SOAP notes for well and abnormal exams Key Features: Reinforces content for Advanced Pediatric Assessment with case studies and multiple choice Q&As that mirror certification exam format Provides essential practice items for the exam Includes Anatomic Labeling Exercises to reinforce required knowledge Delivers essential terminology Offers sample documentation and space for students to practice their own documentation

skin assessment documentation sample: Nursing Interventions & Clinical Skills - E-Book Anne Griffin Perry, Patricia A. Potter, Martha Keene Elkin, 2011-05-05 With its new condensed format, completely reorganized and updated content, respected author team, and new lower price, Perry and Potter's Nursing Interventions and Clinical Skills, 5th Edition is your all-around best choice for learning the skills and techniques you'll use every day in practice. Covering 181 skills, this highly accessible manual conveniently groups all related skills together, so you can find information quickly. The companion Evolve website features 50 video clips, skills checklists, and much more, ensuring your successful mastery of each skill. Contains 180 skills and techniques (basic, intermediate, and advanced) you'll use every day in practice. Presents every skill in a logical, consistent format: Assessment, Planning, Implementation, Evaluation -- improving the quality of patient care. Pairs each step with an appropriate rationale, helping you understand and remember why specific techniques are used. Features Safety Alerts that highlight unusual risks inherent in the next step of the skill, helping you plan ahead at each step of nursing care. Uses a Glove icon as a reminder to don clean gloves before proceeding to the next step of the skill, improving patient safety. Guides you in Delegation and Collaboration, explaining when to delegate a skill to assistive personnel, and indicating what key information must be shared. Highlights Special Considerations such as information unique to pediatric or geriatric patients, to raise awareness of additional risks you may face when caring for a diverse patient population. Provides sample documentation of nurses notes so that you can learn to communicate effectively to the patient care team. Contains multimedia resources such as video clips, skills performance checklists, interactive exercises, and more, all easily available to you on the companion Evolve website at no additional cost. Content has been reorganized to make topics easier to find, improving ease of use. Covers new topics that will help you develop the skills needed to practice according to the TJC and ACCN recommendations. Covers

new skills that will prepare you for nursing practice in a wide variety of environments. Features a unique new chapter, Using Evidence in Practice, that introduces you to using evidence to solve clinical problems. Introduces you to Consistent Patient Identification Protocol as recommended by The Joint Commission, improving quality of care and patient safety. Includes enhanced and greatly expanded end-of-chapter exercises, now featuring case study questions, NCLEX alternate format questions, and multiple-choice questions.

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Authored and contributed by respected experts in wound care management - members of Wound, Ostomy and Continence Nurses Society (WOCN) and Wound Healing Society (WHS). Risk assessment scales are included to assist with determining a patient's risk for developing a wound. Assessment tools are provided to assist the clinician with wound evaluation, care, and treatment. Patient compliance and guidance on how to identify and resolve issues of non-compliance are discussed in the new Facilitating Adaptation chapter. The multidisciplinary approach to wound care management is discussed in a single chapter and applied throughout the text to demonstrate how this approach works and why it is critical to successful patient outcomes. A wound care product formulary lists wound care products by category, usage guidelines (indications and precautions), and helpful hints is included to facilitate outcomes measurement and quality improvement. Algorithms demonstrate the critical steps for topical wound care management. Key information is highlighted in box or table format to enable the user to quickly focus on selected information. Clearly defined chapter objectives provide a focused guide to key elements within each chapter. A self-assessment exercise is included at the end of each chapter to provide a review of critical chapter concepts. Seven new chapters: The Multidisciplinary Team Approach to Wound Management; Skin Care Needs of the Obese Patient; Foot and Nail Care; Facilitating Adaptation; Support Surfaces; Devices and Technology in Wound Care; and Reimbursement and Billing. Revisions to every chapter reflect the most recent advances in disease etiology, diagnosis, and treatment. Updated content reflects the latest technologic advances and therapies to strengthen the clinician's knowledge base in available treatment options. Assessment tools to assist the clinician with evaluation, care, and treatment. Explanation of how to set up a practice and the principles of practice development.

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