RIVERSIDE MEDICAL CENTER, INC.

DR. PABLO O. TORRE MEMORIAL HOSPITAL

METRO PACIFIC HEALTH
THE HEART OF FILIPINO HEALTHCARE

DEPARTMENT: Nursing Service Division		**POLICY NUMBER:** DPOTMH-IPP-NSD-P030 (01)	
TITLE/DESCRIPTION: **SKIN INTEGRITY**			
EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 1 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	

PURPOSE:

To establish guidelines for the prevention, assessment, and management of skin integrity issues, ensuring early identification and intervention to minimize the risk of pressure injuries, wounds, and other skin breakdowns among patients.

DEFINITIONS:

Skin Integrity – The overall health and intactness of the skin, which serves as a protective barrier against infection, injury, and fluid loss.
Pressure Ulcer (Pressure Injury) – Localized damage to the skin and underlying tissue, typically over a bony prominence, caused by prolonged pressure, friction, or shear.
High-Risk Patient – A patient with conditions such as immobility, incontinence, malnutrition, diabetes, or poor circulation that significantly increases the risk of skin breakdown.
Moderate-Risk Patient – A patient with partial mobility limitations, occasional moisture exposure, or mild nutritional deficiencies, requiring regular skin integrity monitoring.
Repositioning – The act of moving a patient to relieve pressure on the skin and prevent pressure ulcers, usually performed every two hours for bedridden patients.
Wound Care – The assessment, cleaning, and dressing of wounds as per physician orders and institutional wound care protocols.
Braden Scale – A commonly used tool for predicting a patient's risk of developing pressure ulcers based on sensory perception, moisture, activity, mobility, nutrition, and friction/shear.
Moisture-Associated Skin Damage (MASD) – Skin breakdown caused by prolonged exposure to moisture from incontinence, wound exudate, or excessive sweating.
Skin Integrity Assessment – A systematic evaluation of the skin for signs of redness, pressure injuries, breakdown, or other abnormalities to prevent complications.
Turning – Act of completely moving the patient from one side to other such that the sacrum of the patient is lifted completely

RESPONSIBILITY:

Nurses, Physician

POLICY:

1. **Upon Admission:**

- Patients who are bedridden, required to remain flat in bed for an extended period (e.g., post-operative patients), experiencing significant body weakness, or at high risk due to conditions such as incontinence, malnutrition, or diabetes must undergo a comprehensive skin integrity assessment. This assessment must be thoroughly documented and reassessed daily to detect early signs of skin breakdown and ensure the prompt implementation of preventive measures

DEPARTMENT: Nursing Service Division		**POLICY NUMBER:** DPOTMH-IPP-NSD-P030 (01)	
TITLE/DESCRIPTION: **SKIN INTEGRITY**			
EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 2 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	

and interventions.

2. **Monitory frequency:**

- High-Risk Patients: Must be monitored every shift (at least every 8 hours) for individuals with severe immobility, unconsciousness, incontinence, malnutrition, or other conditions that significantly increase the risk of pressure ulcers.

  Examples:
  - A stroke patient who is bedridden with no voluntary movement.
  - A post-operative patient required to remain flat in bed for an extended period.
  - An ICU patient on mechanical ventilation with limited mobility.
  - A paralyzed patient with no sensation or ability to reposition independently.
  - A severely malnourished or cachectic patient with fragile skin.
  - A patient with uncontrolled diabetes and poor circulation.
- Moderate-Risk Patients: Must be monitored every 24 hours or sooner if their condition changes, particularly for patients with partial mobility limitations, occasional moisture exposure, or mild to moderate nutritional deficiencies.

  Examples:
  - A post-surgical patient who can move with assistance but is hesitant due to pain.
  - An elderly patient with mild weakness who requires a walker but spends prolonged periods in bed.
  - A patient with intermittent urinary or fecal incontinence requiring diaper changes.
  - A patient with mild malnutrition or dehydration that may affect skin integrity.
  - A patient with early-stage neuropathy affecting their ability to sense pressure

3. As Needed (PRN):

- Wound Care: Wounds shall be assessed and dressed daily or as necessary, following the attending physician's orders.

4 Patient Transfer:

- The skin integrity assessment tool shall be completed and included as part of the endorsement process during the transfer of patients from one nursing area to another, ensuring continuity of care.

5. Documentation:

- All nursing interventions related to skin integrity management, including repositioning, wound care, and preventive measures, shall be clearly documented in the nurse's record for ongoing monitoring and evaluation.

DEPARTMENT: Nursing Service Division		**POLICY NUMBER:** DPOTMH-IPP-NSD-P030 (01)	
TITLE/DESCRIPTION: **SKIN INTEGRITY**			
EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 3 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	

PROCEDURE (SOP):

1. Upon Admission:

- The Nurse conducts a comprehensive skin integrity assessment for patients who are bedridden, required to remain flat in bed for an extended period (e.g., post-operative patients), experiencing significant body weakness, or at high risk due to conditions such as incontinence, malnutrition, or diabetes.
- The Nurse documents the assessment findings and reassess daily to detect early signs of skin breakdown and implement preventive measures as needed.

2. Monitoring Frequency:

2.1 For High-Risk Patients:

- The Nurse monitors patients every shift (at least every 8 hours) for individuals with severe immobility, unconsciousness, incontinence, malnutrition, or other conditions that significantly increase the risk of pressure ulcers.

Examples:

- A stroke patient who is bedridden with no voluntary movement.
- A post-operative patient required to remain flat in bed for an extended period.
- An ICU patient on mechanical ventilation with limited mobility.
- A paralyzed patient with no sensation or ability to reposition independently.
- A severely malnourished or cachectic patient with fragile skin.
- A patient with uncontrolled diabetes and poor circulation.

Nursing Interventions:

- Reposition or turning the patient every 2 hours to alleviate pressure on vulnerable areas (e.g., heels, sacrum, elbows, and shoulders).
- Use pressure-relieving devices (e.g., air mattress).
- Apply moisture barrier creams to protect at-risk areas from incontinence as ordered by the physicians.
- Ensure proper nutrition, focusing on protein, vitamins, and minerals to support tissue repair and skin integrity.
- Assess skin for early signs of breakdown, such as redness or irritation, and document the findings.

DEPARTMENT: Nursing Service Division		**POLICY NUMBER:** DPOTMH-IPP-NSD-P030 (01)	
TITLE/DESCRIPTION: **SKIN INTEGRITY**			
EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 4 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	

For Moderate-Risk Patients:

- The Nurse monitors patients every 24 hours or sooner if their condition changes, particularly for patients with partial mobility limitations, occasional moisture exposure, or mild to moderate nutritional deficiencies.

Examples:

- A post-surgical patient who can move with assistance but is hesitant due to pain.
- An elderly patient with mild weakness who requires a walker but spends prolonged periods in bed.
- A patient with intermittent urinary or fecal incontinence requiring diaper changes.
- A patient with mild malnutrition or dehydration that may affect skin integrity.
- A patient with early-stage neuropathy affecting their ability to sense pressure.

Nursing Interventions:

- Reposition or turning the patient every 2-4 hours, as tolerated, to alleviate pressure.
- Ensure the use of pressure-relieving devices (e.g., air mattress).
- Encourage early mobilization to prevent prolonged immobility and enhance circulation.
- Maintain optimal hydration and nutrition to prevent skin breakdown.
- Monitor for any changes in the skin condition and report immediately if signs of breakdown are detected.

3. As Needed (PRN):

- **Wound Care:**
  - The Nurse assesses and dress wounds daily or as necessary, following the attending physician's order.

4. Patient Transfer:

- The Nurse completes the skin integrity assessment tool according to severity and include it as part of the endorsement process during the transfer of patients, ensuring continuity of care.

5. Documentation:

- The Nurse documents all nursing interventions related to skin integrity management, including repositioning, wound care, and preventive measures, in the nurse's record for ongoing monitoring and evaluation.

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TITLE/DESCRIPTION: **SKIN INTEGRITY**			
EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 5 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	

WORK INSTRUCTION:

KEY TASK	PERSON RESPONSIBLE
1. Assesses the patient for skin integrity using the Skin Integrity Assessment Form upon admission.	ER nurse
2. Endorses any findings to the floor nurse (receiving nurse), including any observations from the resident/intern on duty.	
3. Validates the findings from the ER nurse and complete the Braden Pressure Ulcer Risk Assessment Form for the patient	Floor nurse/receiving nurse
4. Determines the presence of Pressure Ulcer	
5. Refers the patient to the physician for further evaluation and treatment	
6. Strictly implements the nursing care plan as ordered by the physician to manage and treat the pressure ulcer.	
7. Continues to monitor the skin integrity of high-risk patients and implement appropriate preventive nursing care	

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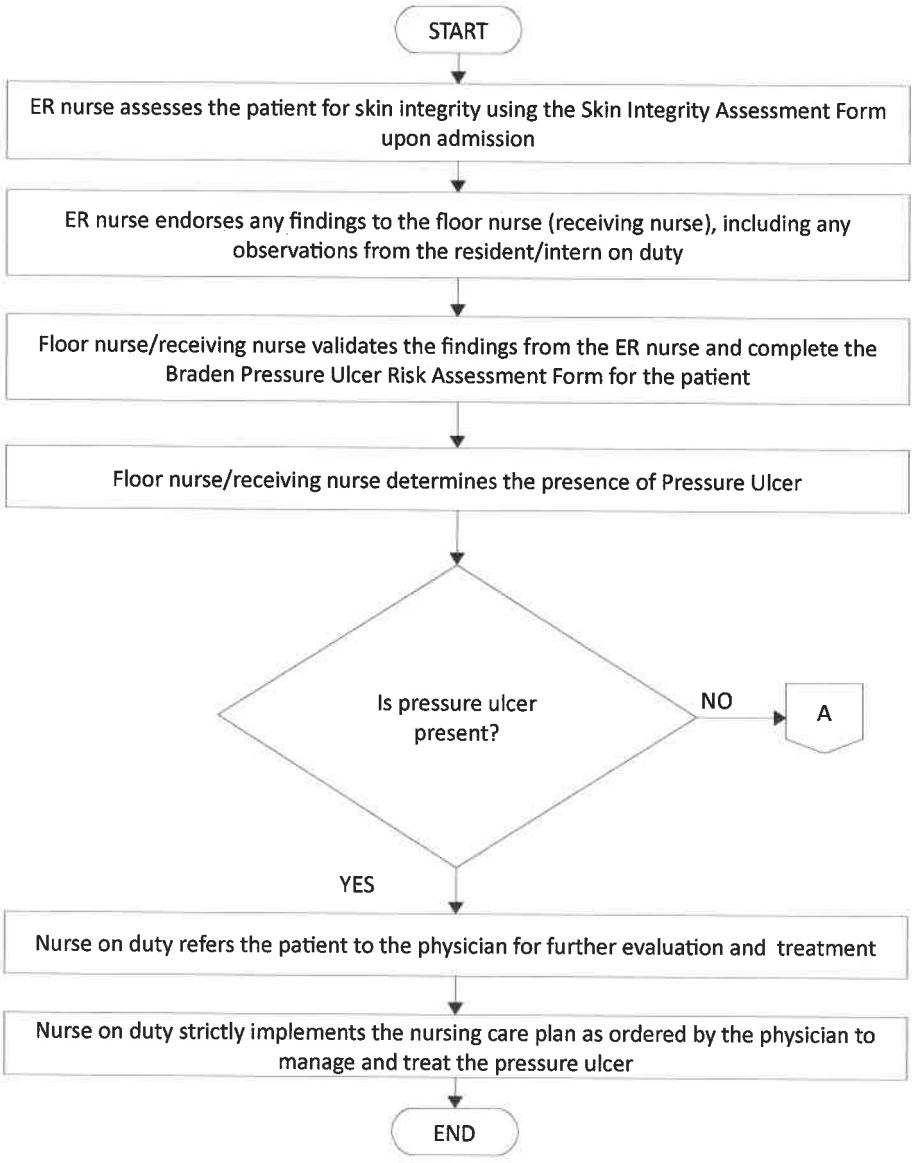
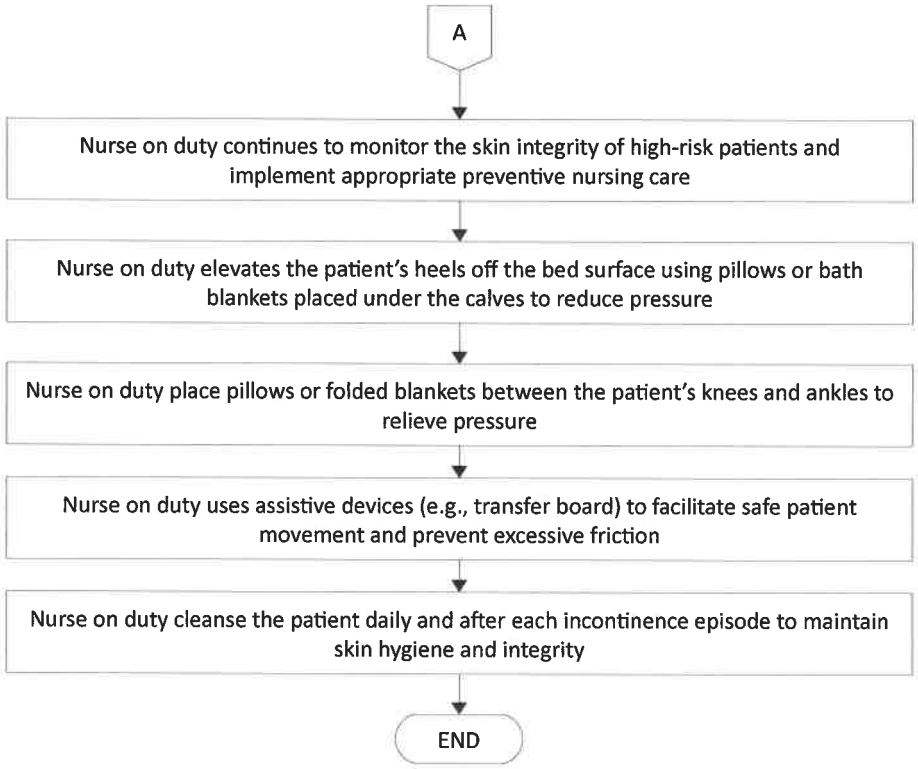
TITLE/DESCRIPTION: **SKIN INTEGRITY**			
EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 6 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	

WORK FLOW:



DEPARTMENT: Nursing Service Division		**POLICY NUMBER:** DPOTMH-IPP-NSD-P030 (01)	
TITLE/DESCRIPTION: **SKIN INTEGRITY**			
EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 7 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	



DEPARTMENT: Nursing Service Division		**POLICY NUMBER:** DPOTMH-IPP-NSD-P030 (01)	
TITLE/DESCRIPTION: **SKIN INTEGRITY**			
EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 8 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	

FORMS:

1. NSD-F019 (01) -Skin Integrity Assessment Sheet

EQUIPMENT: N/A

REFERENCES:

1. **National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel, & Pan Pacific Pressure Injury Alliance.** (2019). *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline.* Cambridge Media.
2. **Cochrane Database of Systematic Reviews.** (2024). *Nutritional interventions for preventing and treating pressure ulcers.* Cochrane.
3. **Centers for Disease Control and Prevention (CDC).** (2021). *Pressure Injuries (also known as pressure ulcers, bedsores, or decubitus ulcers*

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EFFECTIVE DATE: April 15, 2025	**REVISION DUE:** April 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 9 of 9
APPLIES TO: Nursing Service Division		**POLICY TYPE:** Internal	

APPROVAL:				
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TQD

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