**Basic Responsibility**

Licensed Nurse, Nursing Assistant

**Purpose**

To communicate with the nurse about the resident's skin condition/integrity after each bath

# **Procedure**

1. Forms will be kept in a bin on the wall (or other convenient place) of every tub room
2. With each bath, the nursing assistant will examine the resident's skin
3. By circling (or making an X) on the figure, the nursing assistant will document all new and pre-existing red areas, bruises, breaks in the skin, unusual lesions and any other skin abnormalities. A one or two word description is adequate
4. If there are no skin problems, then "no problem" can be written in the corner of the form
5. The box should always be marked indicating that the resident’s fingernails were cleaned and trimmed with the bath. If this box is not checked the nursing assistant is to provide a written reason on the bath slip indicating why nail care was not completed. Indicate whether the resident’s toenails need to be trimmed.
6. Once the skin observation form is filled out, signed and dated by the nursing assistant, it is turned in to the nurse on duty. This is to occur soon after the bath is given, not at the end of the shift.
7. The nurse will follow up on all ***new*** conditions, then sign and date. If the resident’s toenails need to be trimmed a podiatry referral will be made.
8. The form is then turned in to Unit Manager, Director of Nursing or Medical Records.