



Expanse

Admission/Shift Assessment –
Integumentary
Add a Skin Alteration

Body Systems Assessment

- Body System
 - Select body systems to document
- Musculoskeletal Acute Condition Present
 - New Acute Conditions
- Traction Present
 - New Traction
- Skin Color
 - New Skin Color Assessment
- Skin Alteration
 - New Skin Alteration
 - Pressure injury present on admission
 - Pressure injury staging

Add a Skin Alteration
 Add a Skin Color Assessment

Stage 1: Non-blanchable erythema of intact skin.
 Stage 2: Partial-thickness skin loss with exposed dermis.
 Stage 3: Full-thickness skin loss.
 Stage 4: Full-thickness skin and tissue loss.
 Unstageable: Obscured full-thickness skin and tissue loss.
 Deep Tissue Injury: Persistent non-blanchable deep red, maroon, or purple discoloration.

 Per NPIAP guidelines, cannot backstage stage 3 or 4 pressure injuries, even if healing. Keep most severe staging for documentation purposes.

Skin alteration details

Interventions

Routine Daily Care + DAILY ✓

Assessments

- Routine Daily Care** ✓
 - Routine Daily Care
 - Activity
 - Ambulate in hall
 - Ambulate in room
 - Bathroom privileges
 - Bedrest
 - Chair
 - Commode
 - Dangle
 - Stand at bedside
 - Turn
 - Up ad lib
 - Other
 - Other activity
 - Level of assistance
 - Independent
 - Set up assistance
 - Stand-by assist
 - 1 person assist
 - 2 person assist
 - Mechanical lift
 - Refused
 - Other
 - Other level of assistance
 - Assistive devices
 - Brace
 - Cane
 - Cane, four point
 - Crutches
 - Gait belt
 - Grasps
 - Prosthesis
 - Walker, front wheel
 - Other
 - Other assistive devices
 - Ambulation duration (minutes)
 - Ambulation distance (feet)
 - Specialty bed
 - Air fluidized
 - Bariatric low air loss
 - Basic air
 - Low air loss
 - Memory foam
 - Other
 - Other specialty bed
 - Head of bed elevation
 - Self-regulated
 - HOB flat
 - HOB less than 20 degrees
 - HOB 30 degrees
 - HOB 45 degrees
 - HOB 60 degrees
 - HOB 90 degrees
 - Other
 - Other head of bed elevation
 - Transport method
 - Ambulatory
 - Bed
 - Cart
 - Stretcher
 - Wheelchair
 - Other
 - Other transport method
 - Appetite
 - Fair
 - Good
 - Poor
 - Increased
 - Other
 - Other appetite

Document only what patient actually did (independent or assisted), not what patient is capable of doing. If patient independent, confirm actions were completed.

Routine Daily Care-
Activity Turn



Interventions	
Skin Risk Screening + QSHIFT	
Assessments	
Braden Scale II	
Braden Scale	
*Sensory perception	<input type="radio"/> 1-Constantly moist <input type="radio"/> 2-Often moist <input checked="" type="radio"/> 3-Occasionally moist <input type="radio"/> 4-Rarely moist
*Moisture	<input type="radio"/> 1-Bedfast <input type="radio"/> 2-Chairfast <input checked="" type="radio"/> 3-Walks occasionally <input type="radio"/> 4-Walks frequently
*Out of bed activity	<input type="radio"/> 1-Constantly immobile <input type="radio"/> 2-Very limited <input checked="" type="radio"/> 3-Slightly limited <input type="radio"/> 4-No limitations
*In bed mobility	<input type="radio"/> 1-Very poor <input checked="" type="radio"/> 2-Probably inadequate <input type="radio"/> 3-Adequate <input type="radio"/> 4-Excellent
*Nutrition	<input type="radio"/> 1-Problem <input checked="" type="radio"/> 2-Potential problem <input type="radio"/> 3-No apparent problem
*Friction and shear	
Pressure injury risk score	16 - At risk for developing pressure injury

Skin Risk Screening-
Braden Scale

Orders	
Add New	
Process	
Favorites Sort Q wound	
Wound Care	
Wound Care	
Wound Care US Mist Therapy	
Wound VAC	
Wound [Aerobe Culture + Gram Stn]	
Wound, Deep [Anaerob/Aerobe Culture+Gram St]	
Consult to Wound Care Nurse	
ED Negative Pressure Wound Therapy	
ED Wound Care/Dressing	

Orders