



Meditech 5.6

Integumentary Assessment 06/26 0610 H00000071958 HWS,TEST INSTRUCTOR

Skin alteration:

- 1 None
- 2 Present/Exists

Skin condition:→

Color within expectations for ethnicity:

Skin turgor-tenting less than 1 second:

Skin piercings:

Skin alteration:→

Document skin to monitor:

(End)

Admission/Shift Assessment –
Integumentary –
Skin Alteration

Skin Alteration 06/26 0621 H00000071958 HWS,TEST INSTRUCTOR

Pressure injury staging:

1 Stage 1	Stage 1: Non-blanchable erythema of intact skin
2 Stage 2	Stage 2: Partial-thickness skin loss with exposed dermis
3 Stage 3	Stage 3: Full-thickness skin loss
4 Stage 4	Stage 4: Full-thickness skin and tissue loss
5 Unstageable	Unstageable: Obscured full-thickness skin and tissue loss
6 Deep tissue injury	DTI: Persist non-blanch deep red/maroon/purple discolor

Skin alteration description:→Pressure injury *

Skin alteration other:

Location (A/P):→Posterior

Location (body):→Coccyx *

Instance list status:→Active *

Pressure injury present on admission:→Yes*

Pressure injury staging:→

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Integumentary –
Skin Alteration



Skin Risk Assessment 06/26 0617 H00000071958 HWS,TEST INSTRUCTOR

Pressure injury risk score:

A total score of 18 or less indicates the patient is **AT RISK** for developing a pressure injury.

A total score of 19 or greater indicates the patient is **NOT AT RISK** for developing a pressure injury.

Sensory perception: →3-Slightly limited *

Moisture: →3-Occasionally moist *

Out of bed activity: →3-Walks occasionally *

In bed mobility: →2-Very limited *

Nutrition: →2-Probably inadequate *

Friction and shear: →2-Potential problem *

Pressure injury risk score: →15 - Risk for pressure injury

(End)

Safety/Risk/Regulatory-
(Braden) Skin Risk Score

Routine Daily Care 06/26 0611 H00000071958 HWS,TEST INSTRUCTOR

Activity: [or free text]

1 Ambulate in hall 7 Dangle

2 Ambulate in room 8 Stand at bedside

3 Bathroom privileges 9 Turn

4 Bedrest 10 Up ad lib

5 Chair

6 Commode

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

Activity: → Turn

Level of assistance: _____

Assistive devices: _____

Ambulation duration (minutes):

Ambulation distance (feet):

Specialty bed: _____

Head of bed elevation: _____

Transport method: _____

Appetite: _____

(End)

Routine Daily Care-
Activity Turn



Any Order Lookup

Search on:

Order Description	Category
Drsg changes by Wound Care RN	Provider Nursing Orders
TCOM Procedure (Wound Care)	Consultations
WOUND (_ED: Skin Adhesive)	ED Nursing
Wound Care	Provider Nursing Orders
WOUND CARE (_ED: Wound Care/Dressing Appli)	ED Nursing
Wound Care Eval/Tx (WC Nur/PT)	Consultations
Wound Care Supplies	Durable Medical Equipment
WOUND CULTURE (Wound Culture And Gram Stain)	Microbiology
Wound Culture And Gram Stain	Microbiology
WOUND CULTURE AND... (Wound Culture And Gram Stain)	Microbiology
WOUND CARE (_ED: Wound Care/Dressing Appli)	ED Nursing
_ED: Wound Care/Dressing Appli	ED Nursing

More

Orders