Apple BITES
Dose from WCEI

WOUND CARE
EDUCATION INSTITUTE®

Comprehensive skin assessment

By Nancy Morgan, RN, BSN, MBA, WOC, WCC, DWC, OMS

Each issue, *Apple Bites* brings you a tool you can apply in your daily practice. Here's an overview of performing a comprehensive skin assessment.

In the healthcare setting, a comprehensive skin assessment is a process in which the entire skin of a patient is examined for abnormalities. It requires looking at and touching the skin from head to toe, with a particular emphasis on bony prominences and skin folds. Comprehensive skin assessment is repeated on a regular basis to determine whether changes in the skin's condition have occurred. The goal of a skin assessment is to identify problem areas promptly for treatment and prevention.

The answers to the questions below will help ensure your skin assessments are truly comprehensive.

When and how often should I perform a comprehensive skin assessment?

- As soon as possible but within 8 hours of admission (or first visit in community settings)
- Ongoing based on the clinical setting and the patient's degree of risk
- More frequently in response to any deterioration in the patient's overall condition
- Before the patient's discharge

What are key points I should remember?

- Take advantage of every patient encounter to evaluate part of the skin. Each time the patient is repositioned is an opportunity to conduct a brief skin assessment.
- Ensure adequate light. Use natural or halogen light, not fluorescent. Fluorescent light imparts a bluish tone to dark skin, making it harder to see skin changes.
- Use an additional light source, such as a penlight, to illuminate hard-to-see skin areas, such as the heels or sacrum.
- Inspect the skin under and around medical devices (e.g., tubing, splints, compression stockings) at least twice daily for signs of pressure-related injury on the surrounding tissue. Conduct more frequent assessments in patients vulnerable to fluid shifts and in those exhibiting signs of localized or generalized edema.
- Remember that you can combine the skin inspection with other assessments.

How do I do the assessment?

- Explain to the patient and family that

What to include in every skin assessment

A comprehensive skin assessment should include the following:

Skin color

- Know the patient's normal skin tone so that you can evaluate changes.
- Look for differences in color between comparable body parts, such as left and right legs.
- Depress discolored areas to see if they blanch.
- Check for redness or hyperpigmentation (areas of skin that are darker than surrounding areas), which may indicate infection or increased pressure.
- Look for paleness, flushing, and cyanosis.
- Remember that changes in coloration may be particularly difficult to see in darkly pigmented skin. It's not always possible to identify redness on darkly pigmented skin, so localized heat, edema, and change in tissue consistency in relation to surrounding tissue (e.g., induration [hardness]) are important indicators of early pressure damage to the skin in patients with darker skin.

Skin temperature

- Use the back of your hand to assess skin temperature for coolness or warmth.
- Compare symmetrical body parts for differences in temperature.

Edema

- Determine if edema is unilateral or bilateral.
- Grade pitting edema by firmly applying pressure in the edematous area for 5 seconds, then releasing the pressure. The grade is based on the indentation that remains in tissues:
  - 1+ (mild): 2-mm depression, barely detectable; immediate rebound
  - 2+ (moderate): 4-mm deep pit; a few seconds to rebound
  - 3+ (severe): 6-mm deep pit; 10 to 12 seconds to rebound
  - 4+ (very severe): 8-mm very deep pit; more than 20 seconds to rebound.

Turgor

- Keep in mind that poor skin turgor is sometimes found in patients who are older, dehydrated, or edematous or who have connective tissue disease.
- To assess skin turgor, pinch the skin near the clavicle or forearm so the skin lifts up from the underlying structure; then let the skin go.
- If the skin quickly returns to place, skin turgor is normal.
- If the skin does not return to place but stays up, it's referred to as "tenting," which is abnormal.

Moisture

- Touch the skin to see if it's wet or dry, or has the right balance of moisture.
- Check if the skin is oily.
- Look for water droplets on the skin and check if the skin is clammy.
- Determine whether these characteristics are localized or generalized.
- Note any odors.

Skin integrity

- Look to see if the skin is intact, without cracks or openings.
- Determine whether the skin is thick or thin.
- Look for bruising and signs of pruritus (itching) such as excoriations from scratching.
- Check for lesions and, if present, whether they're raised or flat.
- Note disruptions in the skin. If a skin disruption is found, identify the type of skin injury.
- Assess for change in tissue consistency in relation to surrounding tissue.
- Ask the patient if he or she is experiencing discomfort, pain, itching, tingling, or numbness.

you will be looking at his or her entire skin and explain the purpose—to identify potential problems.

- Perform the assessment in private.
- Minimize exposure of body parts during the skin assessment.
- Conduct a systematic, head-to-toe assessment, with particular focus on skin overlying bony prominences, such as the sacrum, ischial tuberosities, greater trochanters, and heels. Check skin folds, between fingers and toes, and under and around medical devices for skin integrity.

Weekly skin assessment

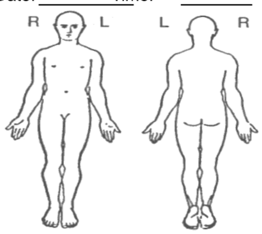
You can **download this tool** from the *Wound Care Advisor* website.

TOOL KIT

Skin Integrity Assessment Form

Skin inspection every shift for high-risk patients (score ≥ 8) and daily inspection for all others

Date: ________ Time: ________



Use numeric key to indicate location

1 Rash ☐ New ☐ Chronic
2 Edema ☐ New ☐ Chronic
3 Bruising ☐ New ☐ Chronic
4 Pressure ulcer ☐ New ☐ Chronic
5 Wound or lesion ☐ New ☐ Chronic
6 At-risk area ☐ New ☐ Chronic
7 Incision/recent surg ☐ New ☐ Chronic
☐ None Apparent

Circle Stage: 1 2 3 4 Unstageable sDTI (see definitions on reverse)

☐ Drsg D&I ☐ Drsg Chg/Location: ________

Wet-Dry Hydrocolloid Transparent Foam Alginate Other: ________

Notes: ________

Devices: Pillow↓heels Lift-sheet Heel protectors Low air loss Barrier Crm

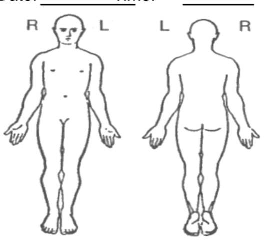
HOB<30° Pillow betw knees Trapeze Elbow protectors Prevention Mattress Flexiseal

Turn Q2H: N/A Time: ____ ____ ____ ____ ____

(Circle: *right,left,back*) R L B R L B R L B R L B R L B

☐ See Ns Notes ☐ Wound Consult Nsg Signature:

Date: ________ Time: ________



Use numeric key to indicate location

1 Rash ☐ New ☐ Chronic
2 Edema ☐ New ☐ Chronic
3 Bruising ☐ New ☐ Chronic
4 Pressure ulcer ☐ New ☐ Chronic
5 Wound or lesion ☐ New ☐ Chronic
6 At-risk area ☐ New ☐ Chronic
7 Incision/recent surg ☐ New ☐ Chronic
☐ None Apparent

Circle Stage: 1 2 3 4 Unstageable sDTI (see definitions on reverse)

☐ Drsg D&I ☐ Drsg Chg/Location: ________

Moist Gauze Hydrocolloid Transparent Foam Alginate Other: ________

Notes: ________

Devices: Pillow↓heels Lift-sheet Heel protectors Low air loss Barrier Crm

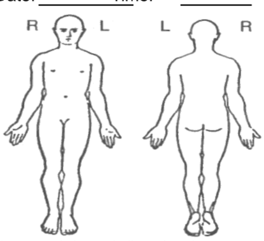
HOB<30° Pillow betw knees Trapeze Elbow protectors Prevention Mattress Flexiseal

Turn Q2H: N/A Time: ____ ____ ____ ____ ____

(Circle: *right,left,back*) R L B R L B R L B R L B R L B

☐ See Ns Notes ☐ Wound Consult Nsg Signature:

Date: ________ Time: ________



Use numeric key to indicate location

1 Rash ☐ New ☐ Chronic
2 Edema ☐ New ☐ Chronic
3 Bruising ☐ New ☐ Chronic
4 Pressure ulcer ☐ New ☐ Chronic
5 Wound or lesion ☐ New ☐ Chronic
6 At-risk area ☐ New ☐ Chronic
7 Incision/recent surg ☐ New ☐ Chronic
☐ None Apparent

Circle Stage: 1 2 3 4 Unstageable sDTI (see definitions on reverse)

☐ Drsg D&I ☐ Drsg Chg/Location: ________

Moist Gauze Hydrocolloid Transparent Foam Alginate Other: ________

Notes: ________

Devices: Pillow↓heels Lift-sheet Heel protectors Low air loss Barrier Crm

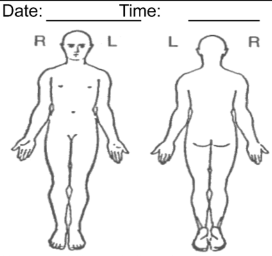
HOB<30° Pillow betw knees Trapeze Elbow protectors Prevention Mattress Flexiseal

Turn Q2H: N/A Time: ____ ____ ____ ____ ____

(Circle: *right,left,back*) R L B R L B R L B R L B R L B

☐ See Ns Notes ☐ Wound Consult Nsg Signature:

Date: ________ Time: ________



Use numeric key to indicate location

1 Rash ☐ New ☐ Chronic
2 Edema ☐ New ☐ Chronic
3 Bruising ☐ New ☐ Chronic
4 Pressure ulcer ☐ New ☐ Chronic
5 Wound or lesion ☐ New ☐ Chronic
6 At-risk area ☐ New ☐ Chronic
7 Incision/recent surg ☐ New ☐ Chronic
☐ None Apparent

Circle Stage: 1 2 3 4 Unstageable sDTI (see definitions on reverse)

☐ Drsg D&I ☐ Drsg Chg/Location: ________

Moist Gauze Hydrocolloid Transparent Foam Alginate Other: ________

Notes: ________

Devices: Pillow↓heels Lift-sheet Heel protectors Low air loss Barrier Crm

HOB<30° Pillow betw knees Trapeze Elbow protectors Prevention Mattress Flexiseal

Turn Q2H: N/A Time: ____ ____ ____ ____ ____

(Circle: *right,left,back*) R L B R L B R L B R L B R L B

☐ See Ns Notes ☐ Wound Consult Nsg Signature:

(continued on next page)

- Include the factors detailed in *What to include in every skin assessment.*
- Document the findings of all skin assessments for communication and tracking. You can download a *Weekly skin assessment* form **here**. (See *Weekly skin assessment.*)

Protecting your patients

A comprehensive skin assessment is essential to detecting early signs of skin breakdown. By using the techniques in this article, you can protect your patients from harm and ensure they receive prompt treatment for identified problems. ■

Weekly skin assessment

(continued from previous page)

Pressure Ulcer Definition

Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers.

Pressure Ulcer Stages

Suspected Deep Tissue Injury:

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue

Further description:

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Stage 1:

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area

Further description:

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk)

Stage 2:

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Further description:

Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Stage 3:

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Further description:

The depth of a stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Stage 4:

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Further description:

The depth of a stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable

Unstageable:

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further description:

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

Selected reference

Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care. AHRQ Publication No. 11-0053-EF, April 2011. Agency for Healthcare Research and Quality, Rockville, MD.

Nancy Morgan, cofounder of the Wound Care Education Institute, combines her expertise as a Certified Wound Care Nurse with an extensive background in wound care education and program development as a nurse entrepreneur.