Weekly skin assessment

TOOL KIT

Skin Integrity Assessment Form

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

Date: ________ Time: ________

R L L R

Key	Type			Key	Type		
1	Rash	☐ New	☐ Chronic	5	Wound or lesion	☐ New	☐ Chronic
2	Edema	☐ New	☐ Chronic	6	At-risk area	☐ New	☐ Chronic
3	Bruising	☐ New	☐ Chronic	7	Incision/recent surg	☐ New	☐ Chronic
4	Pressure ulcer	☐ 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

Use numeric key to indicate location ☐ See Ns Notes ☐ Wound Consult Nsg Signature:

Date: ________ Time: ________

R L L R

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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

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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.