Conducting a Comprehensive Skin Assessment

Presented by
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Welcome!

Thank you for joining this webinar about how to conduct a comprehensive skin assessment.

Skin - the largest organ

Assessment is more than the surface
A Little About Myself...

• An associate professor at Montana State University
• Executive editor of the *Journal of the World Council of Enterostomal Therapists* (JWCET) and WCET International Ostomy Guidelines (2014)
• Member of the editorial board of *Ostomy Wound Management* and *Advances in Skin and Wound Care*
• Legal consultant and former NPUAP board member
Today We Will Talk About

• Attributes and goals of comprehensive skin assessment
• How to conduct comprehensive skin assessment
• Treating comprehensive skin assessment as a separate process
• Integrating comprehensive skin assessment into the normal workflow
• Documenting and reporting results
• Improving comprehensive skin assessment
• Comprehensive skin assessment and care planning
Today We Will Talk About

These skin assessment topics were introduced in your 1-day training. Today, we will revisit them in depth.

Please make a note of your questions. Your Quality Improvement (QI) Specialists will follow up with you after this webinar to address them.
Attributes and Goals of Comprehensive Skin Assessment

- Attributes of comprehensive skin assessment
- Goals of comprehensive skin assessment
Attributes of Comprehensive Skin Assessment

• Process of examining entire skin for abnormalities
• Requires looking at and touching skin from head to toe
Goals of Comprehensive Skin Assessment

• Identify any pressure ulcers.
• Find out if there are other lesions or skin-related factors that predispose the patient to develop pressure ulcers.
  – Factors include excessively dry skin and moisture-associated skin damage (MASD).
Goals of Comprehensive Skin Assessment

• Identify other important skin conditions.
• Provide data needed to calculate pressure ulcer incidence and prevalence.
• Stratify risk.
  – Patients with existing pressure ulcers are at risk for more.
• Identify care planning needs.
How To Conduct Comprehensive Skin Assessment

• Standard protocol for comprehensive skin assessment
• 5 parameters of comprehensive skin assessment
• Skin assessment of bariatric patients
Standard Protocol for Comprehensive Skin Assessment

- Explain to the patient and family that you will be checking the patient’s entire skin.
  - Explain what you are looking for with each site.
- Conduct the assessment in a private space.
- Make sure the patient is comfortable.
- Wash and sanitize your hands before and after the assessment.
Standard Protocol for Comprehensive Skin Assessment

• Wear gloves, and change them as needed.
• Minimize exposure of body parts.
  – Provide privacy with a sheet or cover.
• Ask for help to turn the patient as needed.

Know your facility’s policies and procedures.
Pay \textit{special attention} to—

- Skin beneath and around any devices or compression stockings
- Bony prominences (heels, sacrum, occiput)
- Skin to skin areas, such as the penis, back of knees, inner thighs, and buttocks
- All areas where the patient—
  - Lacks sensation to feel pain
  - Had a breakdown previously
- Also pay special attention if the patient is getting epidural/spinal pain medicines.
5 Parameters of Comprehensive Skin Assessment

1. Temperature
2. Turgor (firmness)
3. Color
4. Moisture level
5. Skin integrity
   – Skin intact
   – Open areas, rashes, etc.
Parameter 1: Skin Temperature

• Palpate with your hand to assess skin temperature.

• Skin warmth or coolness can indicate skin damage, including—
  – Stage I pressure ulcer
  – Suspected deep tissue injury
  – Preulceration in the diabetic foot
  – Inflammation or infection
Parameter 2: Skin Turgor (Firmness)

- Skin normally returns to its original state quickly when stretched.
- Can you “tent” the skin?
- Skin may be slow to return to its original shape in older or dehydrated patients.
Parameter 3: Skin Color

• Compare adjacent areas of skin for color.
• Redness can indicate many skin problems—
  – Pressure ulcer
  – Rash
  – Infection, cellulitis
• Deficiencies can also affect skin:
  – Vitamin C deficiency causes purplish blotches on lightly traumatized areas.
  – Zinc deficiency causes redness of the nasolabial fold and eyebrows.
Parameter 3: Skin Color

- Blanchable versus nonblanchable erythema
- Purple or bruised looking skin
- Paper-thin skin
- Dark or reddened areas

*Darkly pigmented skin does not blanch.*
Parameter 3: Skin Color

Redness

• Reddened skin on the sacral area can be from a variety of etiologies.
• Make sure to get the etiology right so you can treat the cause appropriately.

Moisture-associated skin damage

Stage I pressure ulcer
Parameter 4: Skin Moisture

Moisture-associated skin damage:

• Skin can be dry (verosis) or damaged from too much wetness (maceration).

• Etiology can be—
  – Incontinence, urine, stool, or both
  – Wound exudate
  – Perspiration, including patients with a fever
  – Between skin folds (especially in bariatric patients)
  – Ostomy or fistula that leaks

• Make sure to get the etiology right so you can treat the cause appropriately.
Parameter 5: Skin Integrity

• Skin should be intact.
• If skin is **not** intact, identify the etiology of the skin problem.
• Etiology could be—
  – Pressure
  – Peripheral vascular (venous or arterial)
  – Neuropathic/diabetic
  – Skin tears (especially forearm of older adults)
  – Trauma
• Make sure to get the etiology right so you can treat the cause appropriately.
Skin Assessment of Bariatric Patients

- Inner aspect of thighs and skin folds
- Rash
- Maceration
- Infection (bacteria or candidiasis)
- Breakdown
Skin Assessment of Bariatric Patients

• Perineum
  – Dermatitis
  – Candidiasis

• Extremities
  – Vascular changes
  – Edema
  – Lymphedema
Comprehensive skin assessment—

• Requires a specific focus by staff.
• Must be standardized and ongoing.
Treating Comprehensive Skin Assessment As Separate Process

**Frequency** of comprehensive skin assessment—

- Depends on the needs of the unit
- May be as often as every shift
- Is most often daily and when the patient is—
  - Newly admitted
  - Moved to a different level of care
  - Transferred
  - Discharged
Each time you—

• **Apply oxygen**, check the patient’s ears for pressure areas from tubing

• **Check bowel sounds**, look at skin folds

• **Reposition the patient in bed**, check the back of the patient’s head
Integrating Skin Assessment Into Normal Workflow

Each time you—

• **Auscultate lung sounds or turn the patient**, check the patient’s shoulders, back, and sacral/coccyx region

• **Check a male patient’s catheter**, check his penis

• **Position pillows under the patient’s calves**, check the heels and feet
  – Use a hand-held mirror to adequately visualize the area.
Each time you—

- **Check IV sites**, look at the patient’s arms and elbows

- **Lift the patient or provide care**, check exposed skin, especially on bony prominences

- **Remove equipment**, check adjacent skin
  
  - This includes TENS units, restraints, splints, oxygen tubing, and endotracheal tubes.
Documenting and Reporting Results

- Documenting results
- Reporting results
Documenting Results

- Document the results of comprehensive skin assessment in each patient’s medical record—even if there are no problems.
- Have a standardized place to record results in the medical record. Options include—
  - Checklist or standardized computer screens with key descriptors of the 5 Parameters
  - Diagram of a body outline where staff can note any skin changes they observe

Make sure all staff know how and where to document results.
PRESSURE ULCER IDENTIFICATION POCKET PAD

Place the patient’s/resident’s name on the top of the pad, date it and place an “X” on the area on the body where you see the skin concern. Give this to the nurse and ask him or her to check the patient/resident. They will follow up as needed.

Date: ______________________  Time: ______________________
Patient’s/Resident’s Name: ________________________________
Reporter: _______________________________________________
Documenting Results

Think about keeping a unit wide log.

For each patient, record—

• **Whether** he/she has pressure ulcers
• **How many** pressure ulcers he/she has
• **Highest stage** of his/her deepest ulcer
• **Treatment** for any existing wounds
Reporting Results

• Include results in all shift reports.
• Make sure results are easy to access.
• If there are problems, report results to team members and to the patient’s health care provider.
Reporting Results

• If you keep a unit wide log*, review the log on a regular basis to:
  – Make sure comprehensive skin assessment has been done for each patient.
  – Make sure the assessment and treatment orders are current.
  – Assess your incidence and prevalence rates.

*Tool 5A
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All staff should know what your unit incidence and prevalence rates are and why they matter.
Train **all staff** on:

- **Who** will conduct comprehensive skin assessment:
  - Nurse aide examines the skin each time he/she cleans or repositions the patient.
  - Nurse makes sure the assessment is comprehensive and documented.

- **Why** to conduct it.
- **When** to conduct it.
- **How** to conduct it.
- **What** to look for.
Improving Comprehensive Skin Assessment

**Encourage** staff to:

- Ask a colleague or expert to confirm their skin assessments.
  - This hones skills and prevents errors.
- Ask questions as needed.
- Report any possible skin abnormalities they come across during routine care.
Skin Assessment and Braden Scale

You need to look at both the skin assessment and the risk assessment from the Braden Scale to plan your care appropriately.
Skin Assessment and Care Planning

**Assessing skin**

**Head-to-toe skin assessment**

**INSPECT AND PALPATE**
Document all skin issues, including:
- Skin color
- Skin temperature
- Skin turgor
- Skin moisture status
- Skin integrity
  - *Pressure ulcer*
  - *Healed pressure ulcer*
  - Moisture
  - Moles
  - Bruises
  - Rashes
  - Incisions
  - Scars
  - Burns
- Any abnormalities

Remember to pay special attention to the feet and heels

**Patient is admitted or readmitted**
DO BOTH
Complete head-to-toe SKIN and PU RISK assessment on admission
Do both more frequently if significant change occurs or per facility protocol

**DOCUMENT**

Report any abnormal findings to HCP and notify & educate patient and family on findings

Zulkowski & Ayello, 2010
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Any Questions?

Thank you for being such great listeners.

Do you have any questions about how to conduct a comprehensive skin assessment? Please refer any questions you have to your QI Specialists.
Resources

• Berlowitz D, VanDeusen C, Parker V, et al. Preventing pressure ulcers in hospitals: a toolkit for improving quality of care. (Prepared by Boston University School of Public Health under Contract No. HHSA 290200600012 TO #5 and Grant No. RRP 09-112.) Rockville, MD: Agency for Healthcare Research and Quality; April 2011. AHRQ Publication No. 11-0053-EF.
  – Tool 3A: Pressure Ulcer Prevention Pathway for Acute Care
  – Tool 3C: Pressure Ulcer Identification Notepad
  – Tool 5A: Unit Log


