How to undertake a skin inspection

Obtain informed consent from the patient by providing a clear explanation of the following:

* Why you wish to inspect their skin i.e. pressure area risk.
* How you will undertake this.
* That you may need to take a photograph for the notes (you must document consent).

Skin Area Assessment

Try and assess skin in good light if possible.

* Ask the patient (and ideally obtain a clear medical history) to ascertain whether they have any previous or current history of skin disease or dry skin conditions.
* Ask if they have had any previous pressure damage and if so where?
* Check all bony prominences - (i.e. heels, sacrum, Ischial tuberosities (the bony prominence evident when seated on your bottom) between the knees, hips, elbows, ears, spine…..)
* Document what you have seen -any broken skin and/or discoloration (‘marking’)
* If a patient has a reddened area (‘marking’) you need to check whether it blanches (see below)

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| **How to check for Blanching** – 1. Apply light finger pressure on the reddened/discoloured area for 5 seconds.
2. Remove finger.

The area should go white then flush red very quickly (within 3 seconds). If the area remains red when the finger is removed this is non-blanching and therefore Category 1 pressure damage.  |

* If there are any large reddened areas you need to check multiple areas of the redness. (Some areas may be blanching whereas others may not).
* Document if the skin is dry (e.g. eczema, skin plaques or skin diseases such as psoriasis).
* Use the skin assessment tool to document your findings.
* Is the skin is wet (due to perspiration, wound exudate or incontinence) is the skin macerated (white and boggy) or excoriated (like the skin is burnt or raw)?
* What is the skin tension (turgor)? Is the skin firm and smooth or baggy and wrinkled?
* Is the patient well hydrated? Gently pinch the skin on the back of the hand- does the skin snap back into shape or loosely fall back in to place?

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| SKIN INSPECTIONFORM |

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| Patient name  | NHS.no. | Assessor  | Date |
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| History of skin disease /issues E.g. –eczema, previous pressure damage, skin allergies such as to Elastoplast or nickel.Any patch testing?Any current or previous referrals to dermatology? |  |

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| Skin management regime What does the patient wash with?What emollients do they use and how often?What is the current turning regime? 2hrly, 4hrly, side to side etc.  |  |

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| --- | --- | --- | --- | --- |
| Areas checked:  | Date, Time &Initials.Comment.Ref Picture 1. | Date, Time &Initials.Comment.Ref Picture 2 | Date, Time &Initials.CommentRef Picture 3 | Date, Time &Initials.CommentRef Picture 4 |
| Ears  |  |  |  |  |
| Back of head  |  |  |  |  |
| Shoulder blades  |  |  |  |  |
| Spine  |  |  |  |  |
| Elbows  |  |  |  |  |
| Hips  |  |  |  |  |
| sacrum |  |  |  |  |
| Between knees  |  |  |  |  |
| Ankles  |  |  |  |  |
| heels |  |  |  |  |
| other |  |  |  |  |

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| Action  |  |  | Signature | date |

### Location of wounds- Picture 2

 

### Location of wounds- Picture 1

 

### Location of wounds- Picture 4

 

### Location of wounds – Picture 3

 