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.  Comment  Ref Picture 3 | Date, Time &  Initials.  Comment  Ref 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

