Appendix B: Skin Assessment

Skin inspection should be based on a head-to-toe assessment of those areas known to be vulnerable for each client (see illustrations for at risk areas). This assessment is best conducted when dressing or undressing in order to better visualize vulnerable areas. Any aids (braces, anti-embolic stockings, etc.) should be removed prior to this inspection.

Vulnerable areas typically include:
- temporal region and occiput of the skull;
- ears;
- scapulae;
- spinous processes;
- shoulders;
- elbows;
- sacrum;
- coccyx;
- ischial tuberosities;
- femoral trochanters;
- knees;
- malleoli;
- metatarsals;
- heels;
- toes;
- areas of the body covered by anti-embolic stockings or restrictive clothing;
- areas where pressure, friction and shear are exerted during activities of daily living; and
- parts of the body in contact with equipment.

Additional areas should be inspected as determined by the individual's condition (NICE, 2001; Weir, 2001).

A comprehensive skin assessment for sites of non-blanching erythema requires both visual and tactile inspection. Early indications of a developing ulcer include:
- Change in colour (redness/erythema), texture and sensation of the skin surface.
- In individuals with darkly pigmented skin, observe for persistent erythema, non-blanching hyperemia, blisters and discolouration (purple/blue localized areas), localized heat (replaced by coolness as tissue is damaged), localized edema and localized induration.

PRESSURE POINTS IN VARIOUS POSITIONS

Client Education – Enabler for Client or Family/Caregiver to Assess Skin for Changes

CHECKING SKIN FOR CHANGES

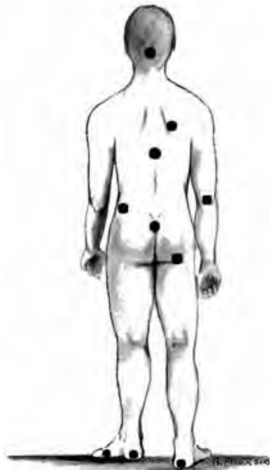
1. Check the whole body, make sure you pay special attention to bony areas.
   - By inspecting skin regularly, you can spot a problem at the very beginning. Checking the skin is the way to spot the warning signals of a problem.
   - Use prevention products on those areas that may be affected by pressure.

2. What should you look for?
   - Redness, blisters, opening in skin, rashes, etc. Feel for heat in red areas with the back of your fingers.

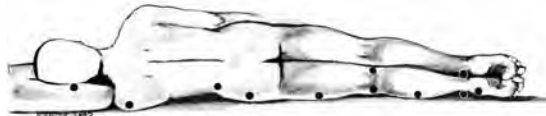
3. Check any areas that may have been previously broken and have since healed over – scar tissue breaks easily.

4. How often should a skin inspection occur?
   - At least twice daily: Morning and evening when dressing or undressing is recommended.
   - Check more frequently if there is an increase in sitting or lying times.
   - It is recommended that you check whenever changing positions.

5. Your caregiver can check your skin, or you can check your skin using a long-handled mirror.



If you have been lying on your back, observe these areas for changes.



If you have been resting on your side, observe these areas for changes.

6. Which parts to check?
   - Check the front, back, and sides of the body.
   - Also check the areas where there may have been pressure.

7. What to do if you notice a change:
   - Apply creams to areas of redness (your nurse will have shown you the barrier creams to use).
   - Show your nurse or doctor as soon as possible (especially if redness does not go away after the pressure has been removed for longer than 15 minutes).
   - Do not massage area.
   - Avoid lying or sitting on reddened area, if possible.

If you have been sitting, observe these areas for changes.

Adapted with permission of Linda Simmons, RN, BScN, Oshawa, Ontario

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