Assessing the Skin in Skilled Facilities

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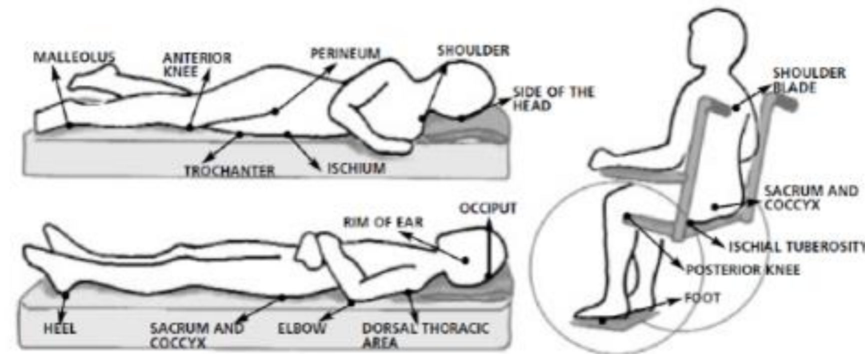
Why are skin assessments important?

- To determine if a resident has any skin problems either upon admission or during their stay at a facility.
- To set up prevention/treatment programs based on scores from a risk assessment tool used in your facility. Remember: Skin assessments are NOT risk assessments and should be done in conjunction with a risk assessment tool.
- To adhere to the guidelines set up by Medicare and be accountable for the residents in the care of the facility.

Common sites for pressure ulcer development



eprimarycare.onf.org/PressureUlcers.html

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How often should skin checks be done?

According to the **National Pressure Ulcer Advisory Panel**, *"Each health care setting should have a policy in place outlining recommendations for a structured approach to skin assessment relevant to the setting that include anatomical locations to be targeted and the timing of assessment and reassessment"*.

- As soon as possible upon admission or readmission, but at least within 8 hours of admission/readmit *(Or first visit in the community setting)*
- As part of every risk assessment
- Ongoing based on the residents degree of risk as indicated on the risk assessment tool
- Prior to the residents discharge
- As indicated for your facility

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How to perform a "full body check"

The ***key*** to an adequate body check is **INSPECTION** and **PALPATION!**

- Make sure the resident is in a comfortable, private setting where all aspects of the skin can be observed.
- Remove clothing and any devices such as oxygen, braces, dressings, etc. as you go along to visualize every aspect of the skin. *(**NOTE**: skin under medical devices should be checked at least **twice daily** for pressure related injury)*
- Check for ***Temperature***, ***Color***, ***Moisture Level***, ***Turgor***, ***Skin Integrity***, ***Edema***, ***Localized Pain*** and ***Any Changes In Tissue Consistency In Relation To Surrounding Tissue.***
- Know the difference between **BLANCHABLE** and **NON BLANCHABLE** erythema and indications for both.

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What happens after a skin assessment is done?

DOCUMENT! DOCUMENT! DOCUMENT!

- In order to be ***most*** useful, the results of the skin assessment must be documented in the resident's **medical record** and **communicated among staff**.

- In addition to the medical record, it is recommended to keep a separate unit log with all comprehensive skin assessments.

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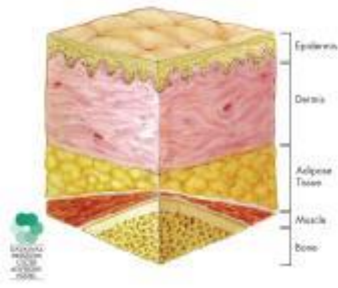
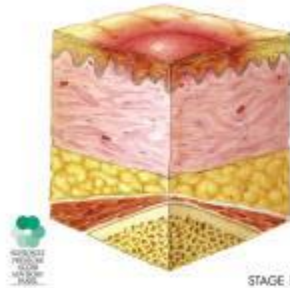
Pressure ulcers - know the difference



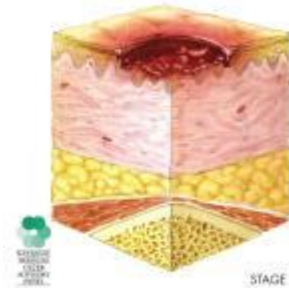
Normal Skin

Dermal layers intact **with no open or erythema** noted.



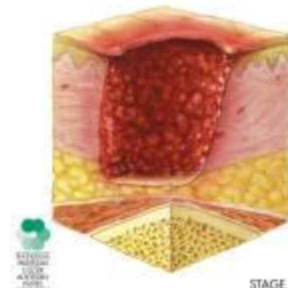
Stage I

Non blanchable erythema of intact skin usually over a bony prominence.



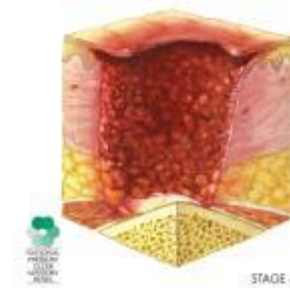
Stage II

Partial thickness loss of dermis presenting as a **shallow open ulcer** with a red pink wound bed without slough. May also present as a **fluid filled blister.**



Stage III

Full thickness tissue loss exposing subcutaneous fat; slough/eschar may be present. May include undermining or tunneling.



Stage IV

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. May include undermining or tunneling.

Unstageable

Full thickness tissue loss in which **depth is completely obscured** by slough and/or eschar.

Deep Tissue Injury (sDTI)

Purple or maroon localized area of discolored **intact skin** or **blood filled blister.**

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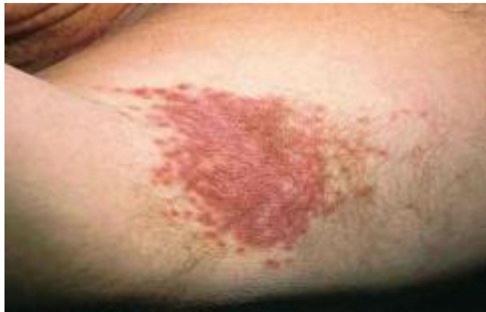
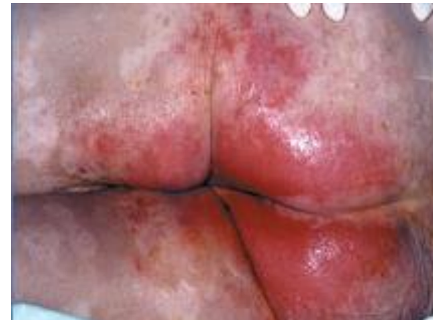
What else besides pressure related problems?



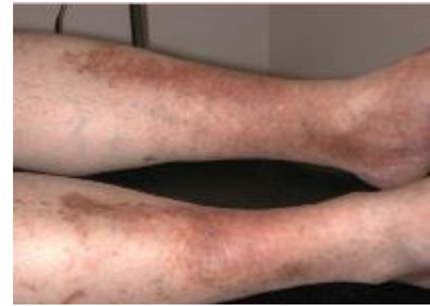
Fungal Infection

Typically found in skin folds of axilla, groins, abdomen, etc. where there is moisture and warmth.



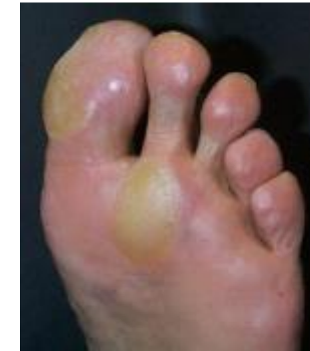
Skin Dermititis aka MASD

Common to buttocks, groins, lower legs from moisture related to urine, sweat, wound/skin drainage



Hemosiderin Staining

Effect of long term venous insufficiency and precursor to lower leg wounds.



Diabetic Foot Callus

Typically found over bony areas to the bottom and sides of the foot. Precursor to a diabetic foot ulcer.

What are risk assessment tools?

Risk Assessment Tools are a standardized way to identify residents ***at risk*** for developing a pressure ulcer, especially if no special preventive interventions are introduced. They will also identify ***different levels of risk*** to allow for the best interventions to be instituted.

The two most widely used **Risk Assessment Tools** are..

The Norton Scale

The Braden Scale

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The Braden Scale

The Braden Scale is a standardized risk assessment tool used to determine a persons risk for development of a pressure ulcer. It consists of six categories:

- Sensory Perception
- Moisture
- Activity
- Mobility
- Nutrition
- Friction/Shear

The total score can range from 6 to 23 with a **LOWER SCORE** indicating a **HIGHER RISK**.

"At Risk" patients score between 15 – 18   **"High Risk"** patients score 10 – 12

"Moderate Risk" patients score 13 – 14   **"Very High Risk"** patients = 9

Interventions for each risk category are then instituted based on facility protocol.

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name________ Evaluator's Name________ Date of Assessment

					Date of Assessment			
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in one or two extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without changes.				
NUTRITION Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats two servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only three servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of four servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of four or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				Total Score				

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The Norton Scale

The Norton Scale is a standardized risk assessment tool used to predict pressure ulcer risk and was the first risk assessment tool to be used. This tool consists of five categories:

- Physical Condition
- Mental Status
- Activity
- Mobility
- Incontinence

The total score can range from 6 to 23 with a **LOWER SCORE** indicating a **HIGHER RISK**.

"At Risk" patients score between 15 – 18 **"High Risk"** patients score 10 – 12

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Interventions for each risk category are then instituted based on facility protocol.

NORTON PRESSURE SORE RISK ASSESSMENT SCALE SCORING SYSTEM

To identify the Norton Rating of residents' risk, mark the number which most aptly describes your residents' condition. The total sum is the Norton Rating (NR) for the resident. This may vary from 20 (minimum risk) to 5 (maximum risk).

PHYSICAL CONDITION	GOOD	4	
	FAIR	3	
	POOR	2	
	VERY BAD	1	
MENTAL CONDITION	ALERT	4	
	APATHETIC	3	
	CONFUSED	2	
	STUPOROUS	1	
ACTIVITY	AMBULANT	4	
	WALKS WITH HELP	3	
	CHAIRBOUND	2	
	BEDRIDDEN	1	
MOBILITY	FULL	4	
	SLIGHTLY IMPAIRED	3	
	VERY LIMITED	2	
	IMMOBILE	1	
INCONTINENCE	NONE	4	
	OCCASIONAL	3	
	USUALLY URINARY	2	
	URINARY AND FECAL	1	

Add up residents' scores, and evaluate their risk according to this table:

OVER 18	LOW RISK
BETWEEN 18 AND 14	MEDIUM RISK
BETWEEN 14 AND 10	HIGH RISK
LESS THAN 10	VERY HIGH RISK

Conclusion

- **Skin Assessments** are an important part of managing residents in Skilled Facilities.
- Identifying skin problems early on can mean **preventing a pressure ulcer** from forming or **further deterioration of other skin issues.**
- **Know your facilities protocols for performing Skin Assessments** and what Risk Assessment Tools are being used.
- Make sure you **document and communicate all Skin Assessments done**, *including those that don't show any problems.*

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