

**Pennsylvania Pressure Ulcer Partnership
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Wound and Skin Assessment – From Novice to Expert
(Or Are You Smarter Than a Sixth Grader?)

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Show What You Know: Answer Key

A

B

C

D

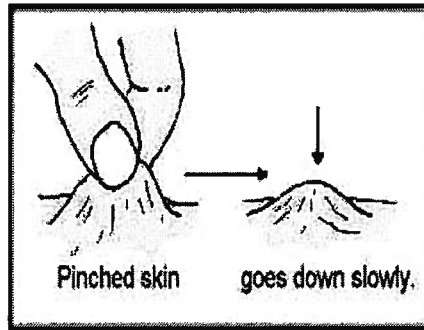
Just How Smart Are You?

Which of the following is a *normal* function of the skin?

- A. Synthesis of vitamin K
- B. Elimination of carbon dioxide
- C. Support immune response by Langerhans cells
- D. Production of sweat while getting grilled by Jeff Foxworthy

What Aspect is Not Part of Routine Skin Assessment?

- A. Color
- B. Turgor
- C. Temperature
- D. Jeff Foxworthy



Your Patient Has a Payne-Martin Lesion.
The Patient Has Which Condition?

- A. Pressure ulcer
- B. Localized atrophy
- C. Skin tear
- D. Jeff Foxworthy rash



Skin and Wound Assessment

- Very different processes
- Assessing different parameters
- Documentation terminology different

Skin vs. Wound Assessment

- Skin assessment – part of routine head to toe assessment of all patients
- Actually look at **entire** body
- Minimal elements of a skin assessment
 - Five parameters

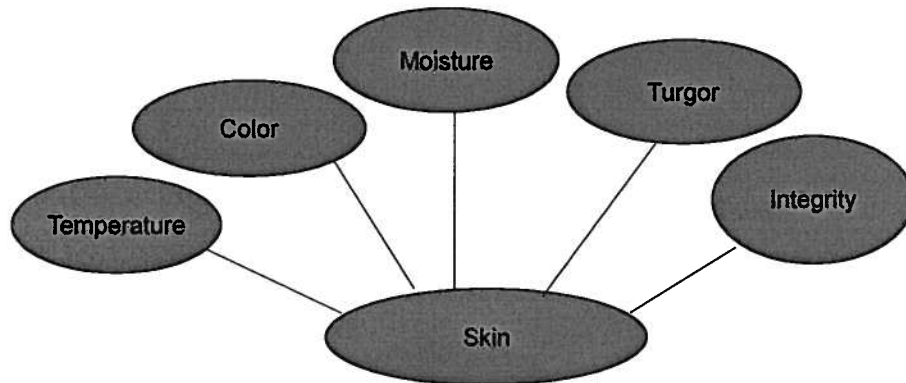
Skin Disorders

- Very common
 - 1/3 of U.S. population has skin disorder
- 8% of all adult outpatient visits
- Skin cancer – Most common malignancy

Skin History

- Personal/family history of skin problems
- Change in skin pigmentation/change in mole
- Excessive dryness/moisture
- Excessive bruising
- Medications used?
- Hair loss?
- Change in nails?
- Self-care rituals
- Family member with skin problem NOW?

Elements of Skin Assessment



Skin Assessment

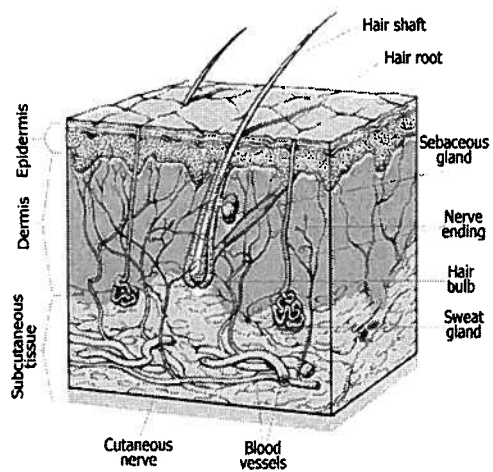
- Temperature – warm, hot, cooler
- Color – tone of skin, hyper or hypopigmentation, pallor, ruddiness
- Moisture – dry, moist, edematous

Skin Assessment

- Turgor - returns to shape
 - Integrity - no open areas
- OR
- Describe injury appropriately

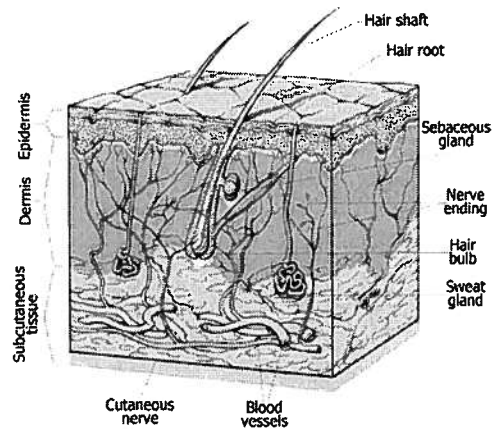
Skin Anatomy

- Layers of the skin:
- Epidermis
- Dermis
- Subcutaneous tissue



Skin Physiology

- Protective covering
- “Acid mantle”
- Sensation
- Thermoregulation
- Excretion
- Metabolism
- Communication
- Immune response



Skin Assessment Issues

- Skin trauma – skin tears
- Skin conditions – xerosis and pruritus
- Skin disorders – rashes, infections

Skin Lesions

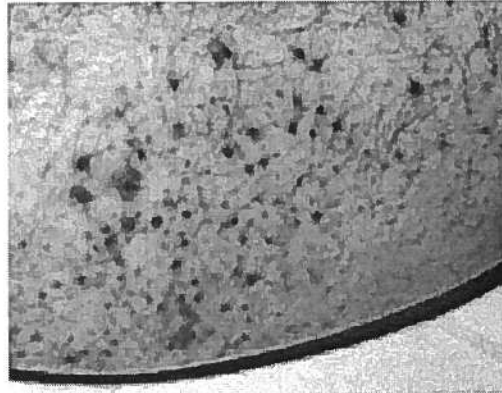
- Primary lesions – appear initially in response to some change in internal/external skin environment
- Secondary lesions – changes in primary lesions

Skin Lesions

- | <u>Primary</u> | <u>Secondary</u> |
|----------------|------------------|
| • Macule | • Scale |
| • Papule | • Excoriation |
| • Nodule | • Crust |
| • Vesicle | • Scar |
| • Pustule | • Atrophy |
| • Patch | • Fissure |
| • Plaque | |
| • Tumor | |
| • Bulla | |
| • Wheal | |

Other Skin Terminology

- Petechiae
- Purpura
- Ecchymosis
- Paronychia



Patterns of Skin Lesions

- Generalized
- Localized
- Annular
- Grouped
- Linear
- Diffuse
- Serpiginous



Wound Assessment

- You know what you can describe
- Half way to diagnosis with good wound description



Many Kinds of Wounds

- Surgical wounds
- Venous ulcers
- Arterial ulcers
- Neuropathic ulcers
- Vasculitic ulcers
- Pressure ulcers*



Pressure Ulcer Risk Scales

Not for wound assessment – for risk

- Norton Scale – 5 factors
- Gosnell Scale – 5 factors
- Braden Scale – 6 factors

Various combinations: Sensory, motor, activity, nutrition, friction/shear, moisture factors

Pressure Ulcer Assessment

- Only wound that is staged – NPUAP – 6 stages
- All other wounds are full or partial thickness

Wound Assessment

Mnemonic - Assessment

Assessment

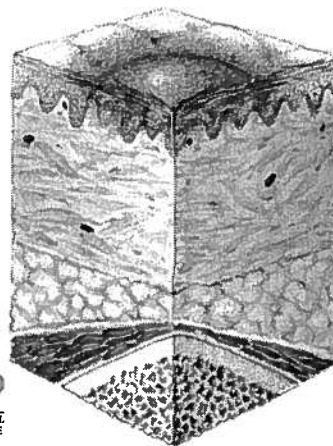
- A - Anatomical location
- S - Size (cm.), stage (pressure ulcer)
- S - Sepsis
- E - Exudate
- S - Surrounding skin
- S - Sinus tract

Assessment

- M - Maceration
- E - Edges, epithelial tissue
- N - Nose (odor), necrosis
- T - Tenderness, tension (induration)

Stage I

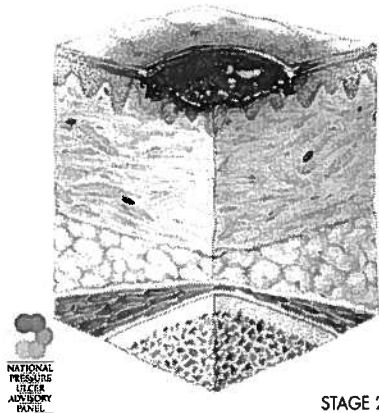
- Non-blanchable erythema
- Intact skin
- Darker skin can be red, purple, darker tone, warmer
- Usually over bony prominence



STAGE I

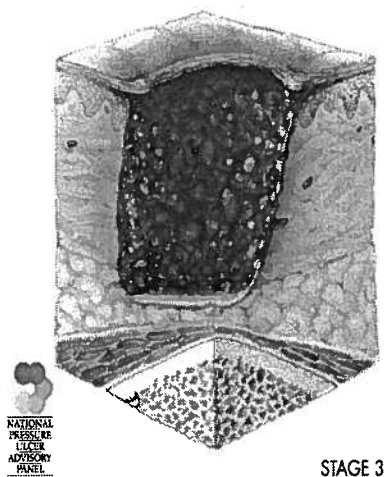
Stage II

- Loss of epidermis (partial thickness)
- Abrasion, clear (serum-filled) blister, shallow opening, not through dermis
- Not for skin tear, tape burn, perineal dermatitis, maceration



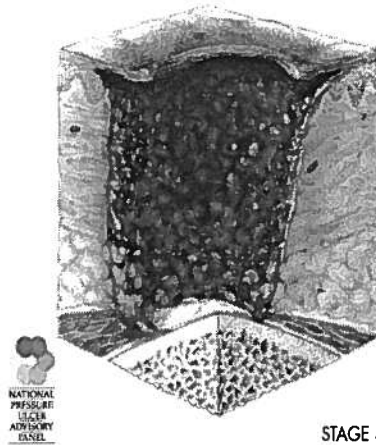
Stage III

- Damage down to but not through subcutaneous tissue
- No bone or muscle showing
- May have undermining or tunneling



Stage IV

- Damage down to and including bone, muscle, tendon, fascia
- Often slough and eschar
- Often undermining and/or tunneling



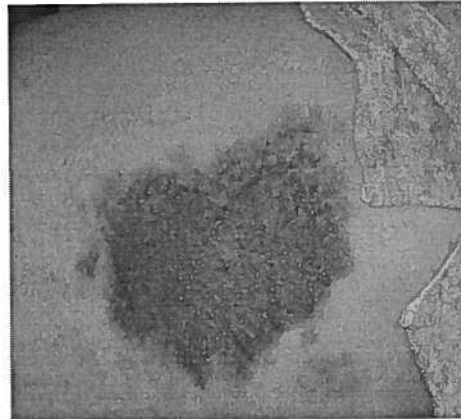
Unstageable Pressure Ulcer

- Wound bed fully eschar/slough covered
- Cannot Stage



Deep Tissue Injury

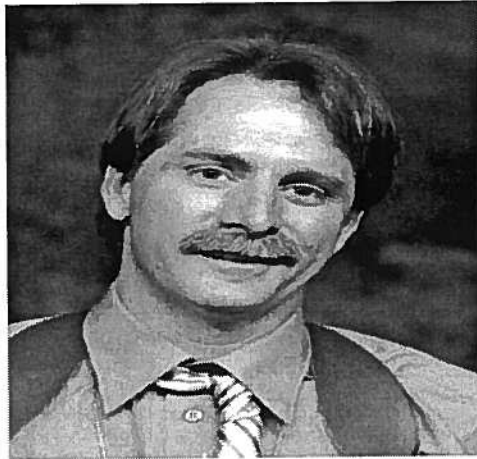
- Intact bruised, discolored skin; dark maroon, purple – shows signs of broken blood vessels
- Blood-filled blister
- May be preceded by tissue that is firm, mushy, boggy, warmer



Are You Smarter Than a Sixth Grader?

Let's Practice Skin and Wound Assessment Skills

What Kind of Ulcer is This?



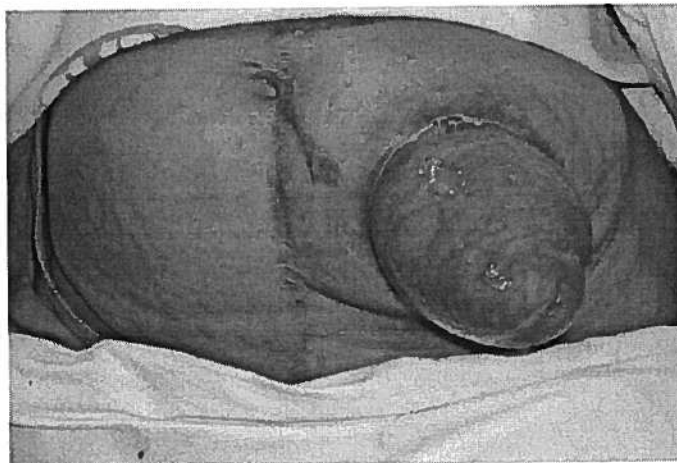
Ready to Graduate to Seventh Grade?



What is it?



What is it?



What is it?



What is it?



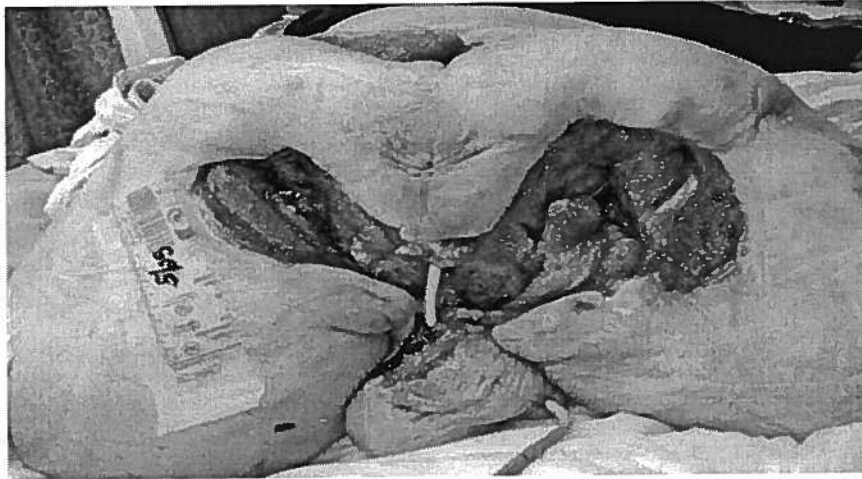
What is it?



What is it?



What is it?



Self-Assessment

- Are you smarter than Jeff Foxworthy?
- Are you smarter than a sixth grader?



Thank you for Playing!

- Join the fight for good skin care and prevention
- Promote comprehensive wound assessment and care
- Take pride in providing safe, cost effective care for patients