Performing a skin assessment

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A SKIN ASSESSMENT captures the patient’s general physical condition, based on careful inspection and palpation of the skin and documentation of your findings. Here are some components of a good skin assessment.

Take a thorough history
Obtain a history of the patient’s skin condition from the patient, caregiver, or previous medical records. Go over the detailed family history with the patient or patient’s family, and make sure all skin conditions are reviewed.

Also obtain a history of the patient’s bathing routine and skin care products. Document the soaps, shampoos, conditioners, lotions, oils, and other topical products that the patient uses routinely. Ask the patient:
- about skin changes such as xerosis (skin dryness), pruritus, wounds, rashes, or changes in skin pigmentation or color
- if skin appearance changes with the seasons
- about any changes in nail thickness, splitting, discoloration, breaking, and separation from the nail bed. A change in the patient’s nails may be a sign of a systemic condition.
- about allergies, including those to medications, topical skin and wound products, and food.

Document your findings in the medical record.

Perform a physical assessment
This includes assessment of skin color, moisture, temperature, texture, mobility and turgor, and skin lesions. Inspect and palpate the fingernails and toenails, noting their color and shape and whether any lesions are present.

Skin lesions can be categorized as primary or secondary, although the distinction isn’t always clear. Make sure you use the correct term to describe any lesions you find. The following are primary lesions:
- macule, a flat, nonpalpable circumscribed area (up to 1 cm) of color change that’s brown, red, white, or tan
- patch, a flat, nonpalpable lesion with changes in skin color, 1 cm or larger
- papule, an elevated, palpable, firm, circumscribed lesion up to 1 cm
- plaque, an elevated, flat-topped, firm, rough, superficial lesion 1 cm or larger, often formed by coalescence of papules
- nodule, an elevated, firm, circumscribed, palpable area larger than 0.5 cm; it’s typically deeper and firmer than a papule
- cyst, a nodule filled with an expressible liquid or semisolid material
- vesicle, a palpable, elevated, circumscribed, superficial, fluid-filled blister up to 1 cm
- bulla, a vesicle 1 cm or larger, filled with serous fluid
- pustule, which is elevated and superficial, similar to a vesicle, but is filled with pus
- wheal, a relatively transient, elevated, irregularly shaped area of localized skin edema. Most wheals are red, pale pink, or white.

Secondary lesions can be caused by disease progression, overtreatment, excessive scratching, or infection of a primary lesion:
- scale, a thin flake of dead exfoliated epidermis
- crust, the dried residue of skin exudates such as serum, pus, or blood
- lichenification, visible and palpable thickening of the epidermis and roughening of the skin with increased visibility of the normal skin furrows (often from chronic rubbing)
- excoriation, linear or punctuate loss of epidermis, usually due to scratching.

Look out for dry skin
In long-term-care facilities, the most common skin problems are xerosis and pruritus. Between 59% and 85% of patients over age 64 have dry skin. More than 70% of patients who are hospitalized and 90% of nursing home residents over age 65 have dry skin. Many factors contribute to dry skin, including a low-humidity environment, the patient’s personal habits (smoking, alcohol intake, and poor nutrition), seasonal changes, chronic diseases, medications, and skin cleaners.

Xerosis is the most frequent cause of pruritus. The patient’s skin may be rough and scaly, with dryness occurring most often over the lower legs, hands, and forearms. Skin dryness isn’t usually associated with a dermatologic condition or systemic disease. Scratching can cause excoriations, which can progress to secondary eczema or a skin infection.

Once you’ve assessed and documented the condition of your patient’s skin, you can formulate an appropriate care plan to maintain skin integrity.

RESOURCES
