Skin assessment is important in pressure injury (PI) prevention, classification, diagnosis and treatment. The assessment:

- Is a head to toe visual inspection and focuses on the skin overlying bony prominences, in skin folds, and around and under medical devices
- Uses touch and palpation to detect differences in skin temperature and soft tissue consistency.

When to conduct skin assessment:

- As soon as possible but within eight hours of presentation or on the first visit in community or ambulatory care settings for people with identified risk factors for pressure injury development
- Reassessment frequency is based on the clinical setting and the individual's level of risk
- On transition of care
- Increase the frequency of skin assessment in response to deterioration.

How to conduct skin assessment:

Differentiate between blanchable and non-blanchable erythema.

Use the finger pressure method where a fingertip is pressed into the skin for three seconds, and the blanching response is assessed following removal of pressure.

- Blanchable erythema - visible skin redness that becomes white when pressure is applied and reddens when pressure is relieved. It may be normal reactive hyperaemia or inflammatory erythema indicating an intact capillary bed
- Non-blanchable erythema - visible skin redness that persists with the application of pressure. It indicates structural damage to the capillary bed/microcirculation. After offloading the site for 30 minutes, if it remains non-blanchable, it is a Stage 1 pressure injury.
Stage 1 Heel Pressure Injury

Avoid positioning the patient on an area of erythema wherever possible

Identifying erythema on darkly pigmented skin is difficult: localised heat, oedema, and changes in soft tissue consistency in comparison to adjacent tissue (e.g. induration/hardness) are important indicators of damage from pressure.

Check for localised heat, oedema, and change in tissue consistency

Changes from the adjacent tissue are warning signs of PI development.

Assess localised pain

Include as part of every skin assessment.

Check medical devices

Inspect the skin under and around medical devices at least twice daily for signs of pressure-related injury. Assess more frequently for patients vulnerable to fluid shifts and/or with oedema.

Whenever a pressure injury occurs due to a medical device, removal or changing the device should be considered when clinically feasible. If the device must remain in-situ, strategies to relieve pressure should be implemented.

Check underneath prophylactic dressings

Assess skin underneath prophylactic dressings at least daily or as per local guidelines or protocols.

Check skin folds

Assess the skin for moisture associated skin damage (MASD) particularly in skin folds of individuals who are obese.

Abdominal pannus MASD. Image courtesy of the IMBED Study, a NSW Health Translational Research Grant recipient.

Document

Document the findings of skin assessments in the medical record.

If an injury is identified ensure a wound management chart is completed and the identification of this injury is escalated and communicated.

Report all healthcare-acquired pressure injuries in the incident management system.

Reference