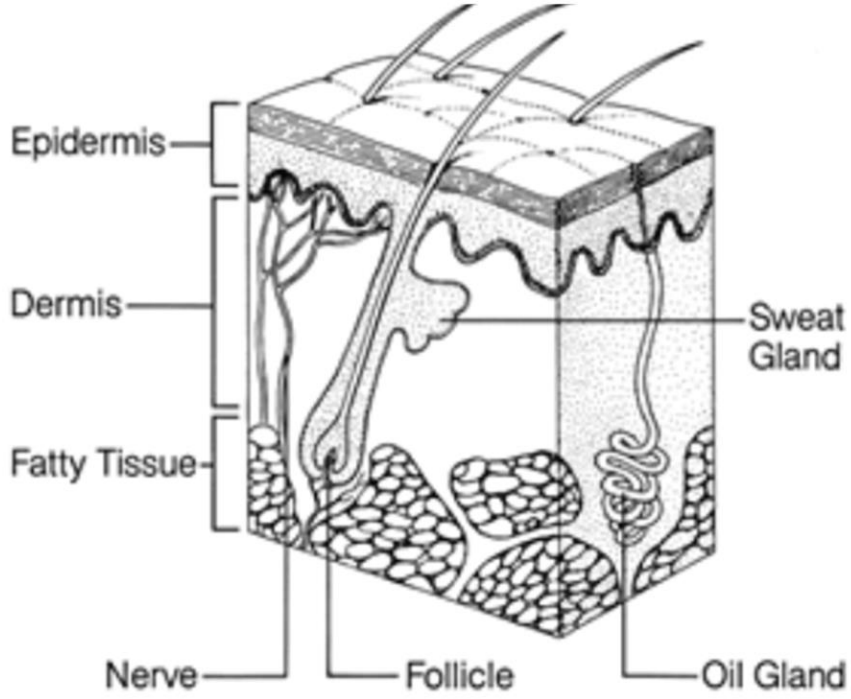
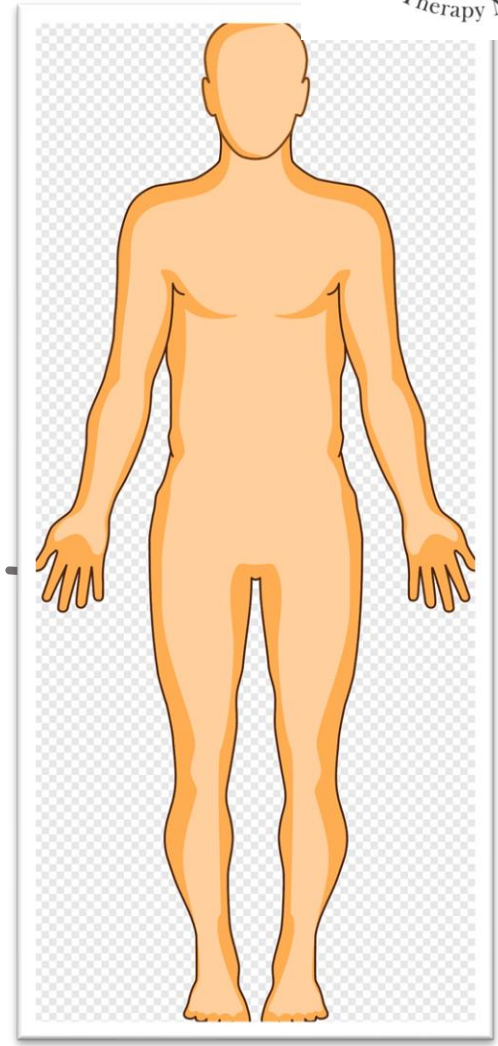
SKIN INSPECTION

Prapai Ariyaprayoon
APN,ETN
RAMATHIBODI HOSPITAL

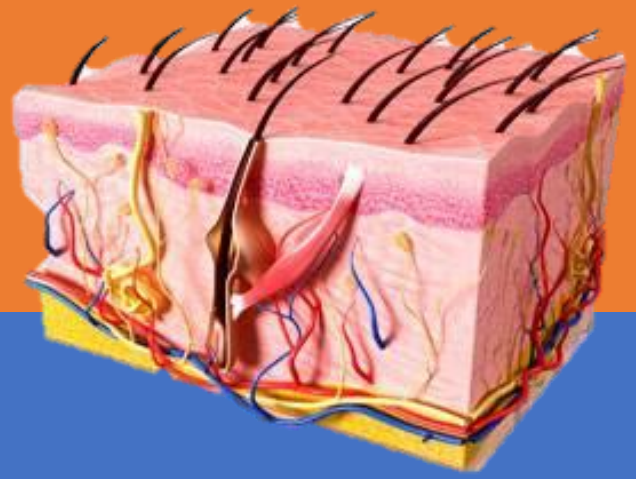
SKIN is largest organ

Assessment is more than the surface





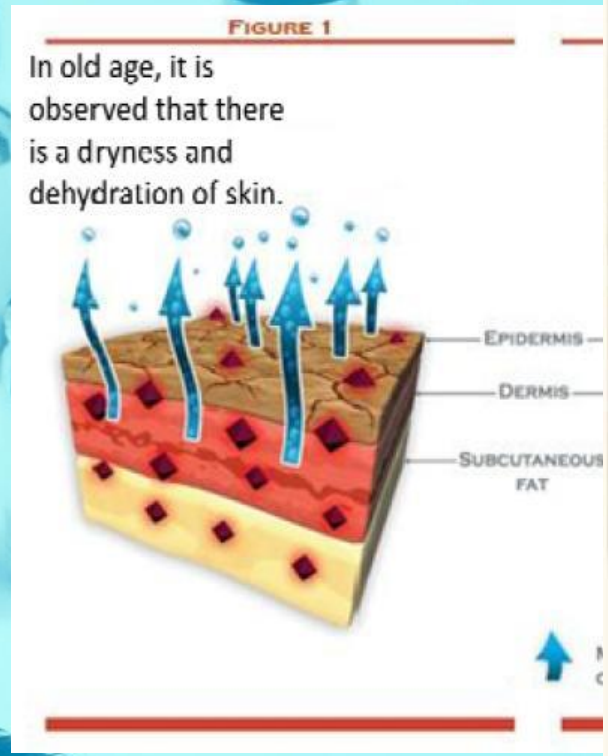
Skin assessment

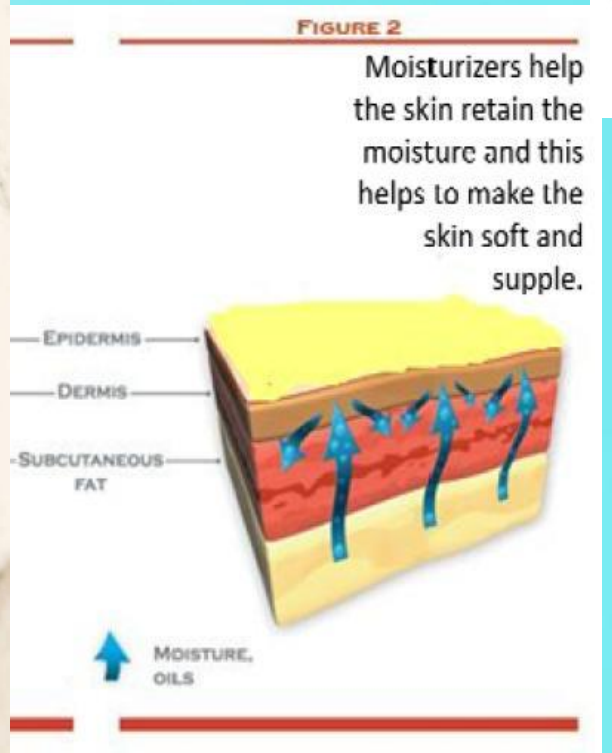


ชั้นผิวหนังกำพร้า

- ปกป้องร่างกายจากสารพิษ/สิ่งระคายเคือง
- ป้องกันการสูญเสียน้ำและเกลือแร่
- ควบคุมอุณหภูมิของร่างกายให้คงที่

กรดอ่อน (pH 5-5.9) โปรตีน 70% ไขมัน 15% และ น้ำ 15%





น้ำชั้นผิว < 10 % มีภาวะผิวแห้ง และเสี่ยงถูกทำลายได้ง่าย

ไขมันชั้นผิวคงอยู่ ค่า pH ที่เหมาะสม

ที่มา: Hachem JP et al., 2005

หลักการประเมินผิวหนัง (Skin assessment)

ตรวจผิวหนังทั้งตัว (inspecting)

การทำความสะอาดผิวหนัง (cleansing)

การให้ความชุ่มชื้นที่เหมาะสม (moisturizing)

การป้องกัน (protection)

Document

So important! Documentation by exception doesn't really work well for skin issues and interventions...

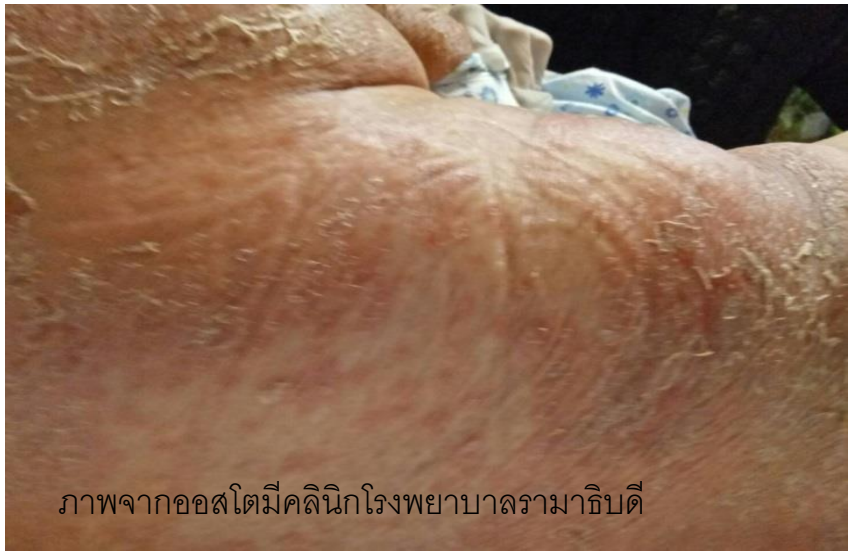
Document the BQ and skin assessment within 24 hours of admit: MUST note if a pressure injury is noted on admit

Document if a pressure injury is present on discharge

- Why?? Regulatory mandates.....

ผิวหนังที่ปราศจากความชุ่มชื้น


ภาพจากออสโตมีคลินิกโรงพยาบาลรามาธิบดี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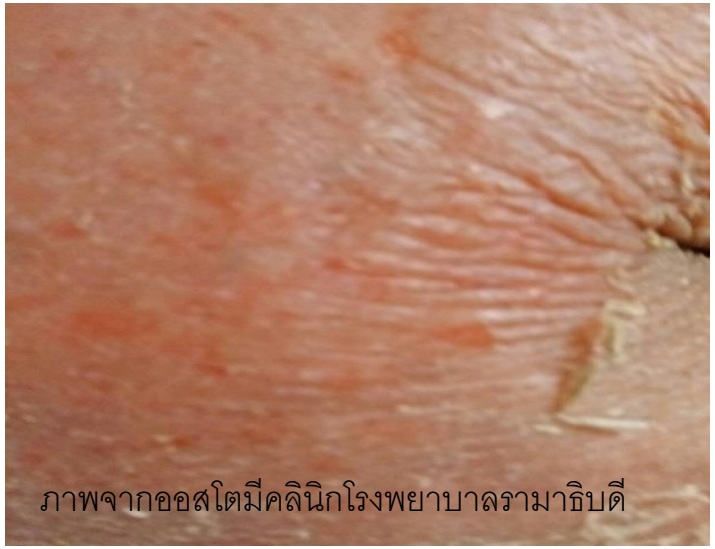
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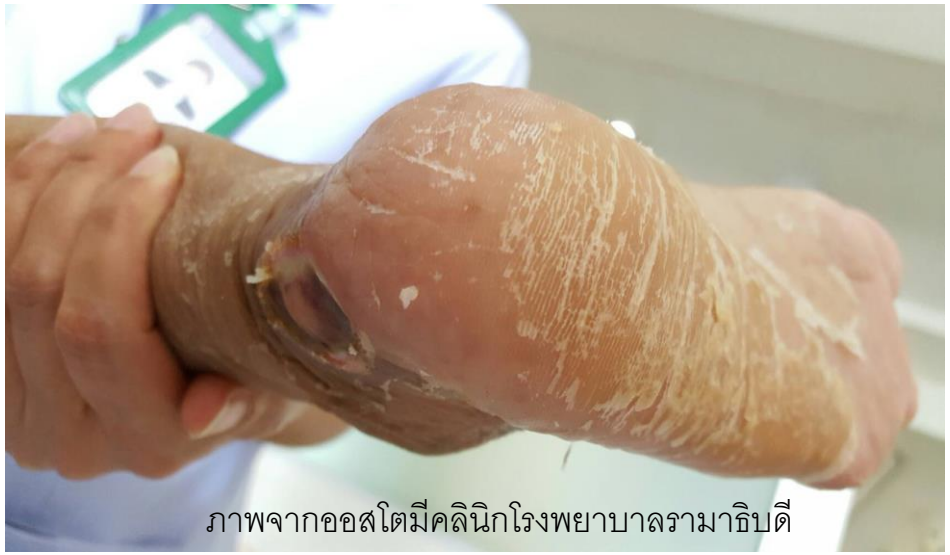
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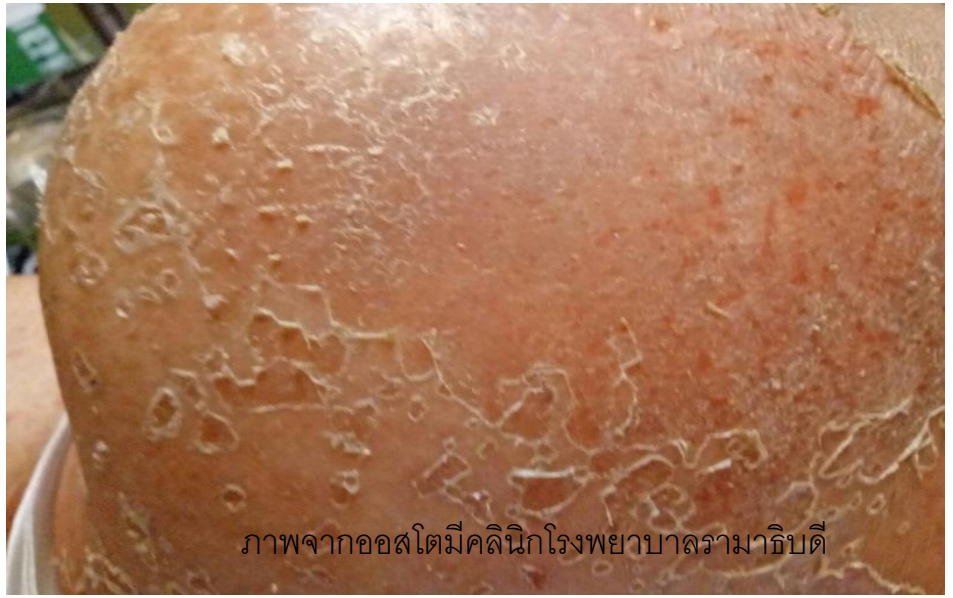
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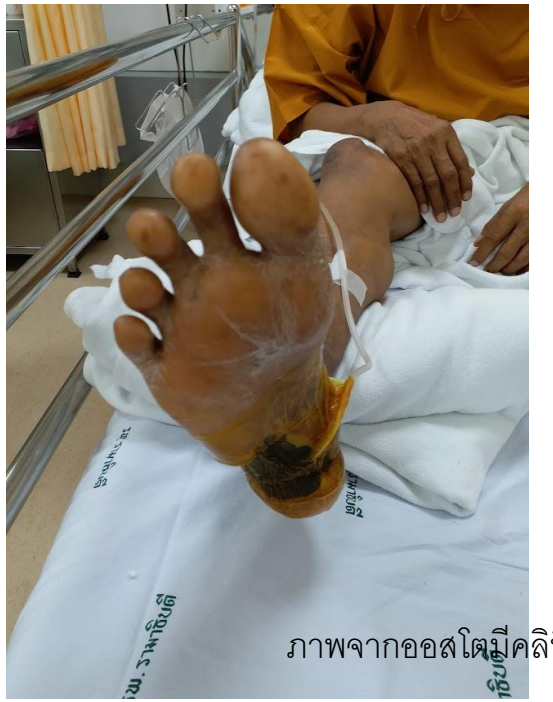
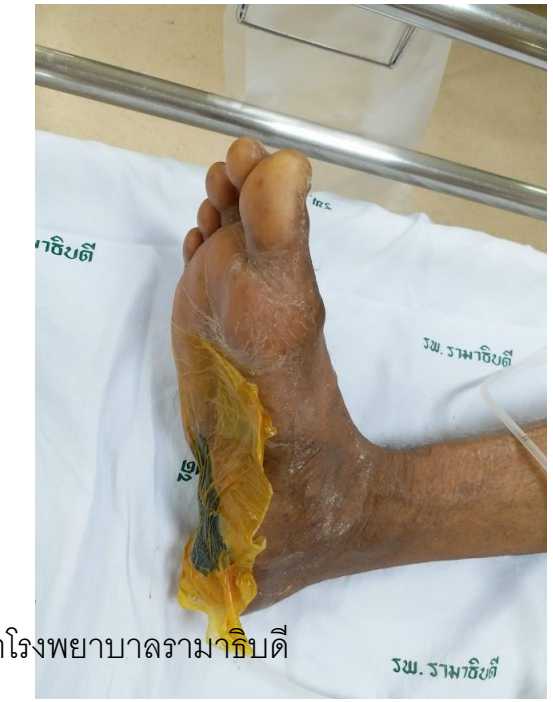
Moisture





ภาพจากออสโตมีคลินิกโรงพยาบาลรามาธิบดี

ให้ความชุ่มชื้นกับผิวหนัง

❖**ป้องกันการสกปรกจาก อุจจาระ ปัสสาวะ ใช้ภาวะ incontinence**

❖Moisturizer เป็นสารที่มีส่วนผสมของน้ำ และ น้ำมัน สามารถป้องการสูญเสียความชื้นของผิวหนังได้ดี

❖Lotion มีส่วนผสมของน้ำมัน หรือ solid paste น้อย จึงมีความสามารถในการป้องกัน Skin break down น้อย

What do you do for prevent PI

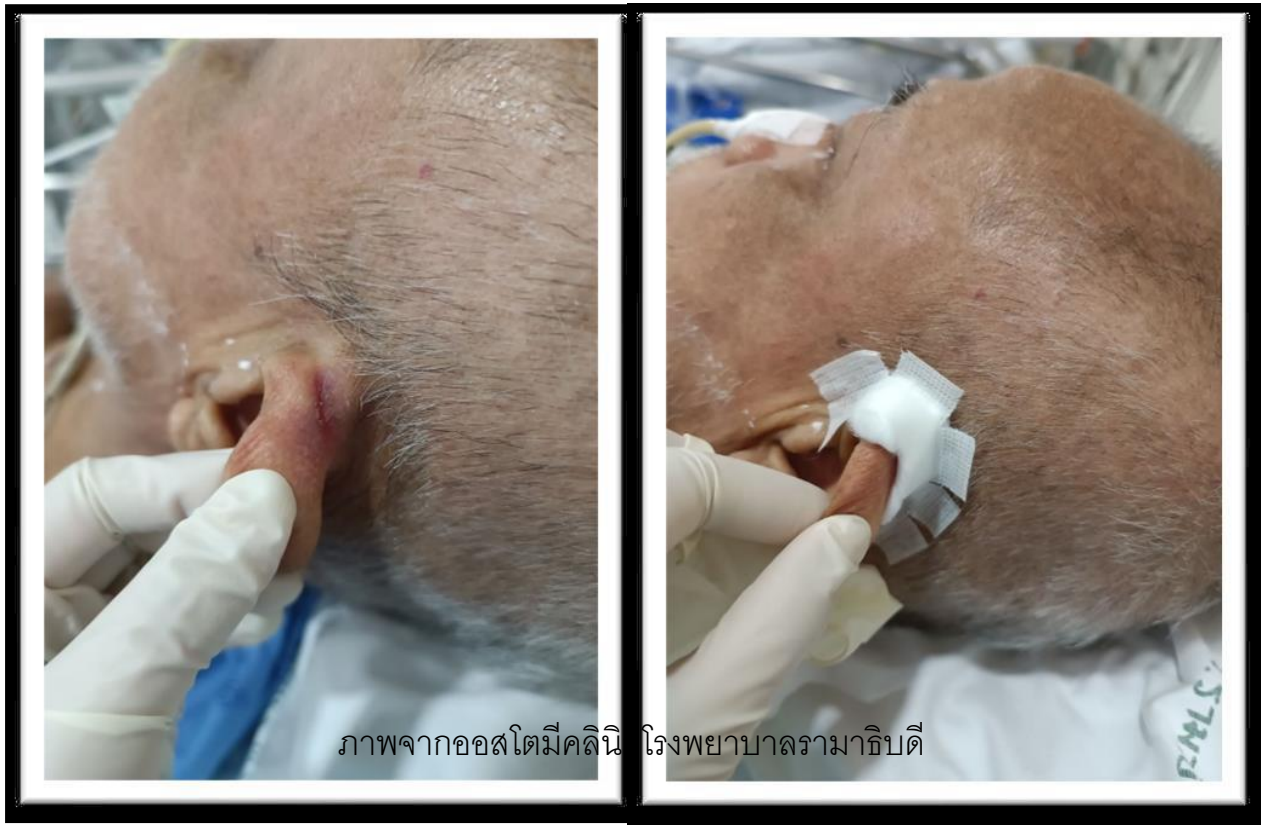
What is the best treatment choice for a pressure injury?

Prevention!

Did You Know?

A Stage 3 or 4 (full skin thickness injury) pressure injury acquired after hospital admission is considered

Stage 3 or 4 Never event at Ramathibodi hospital



สิ่งที่ต้องการทราบ คือ

เมื่อผู้ป่วยมารักษาที่โรงพยาบาล

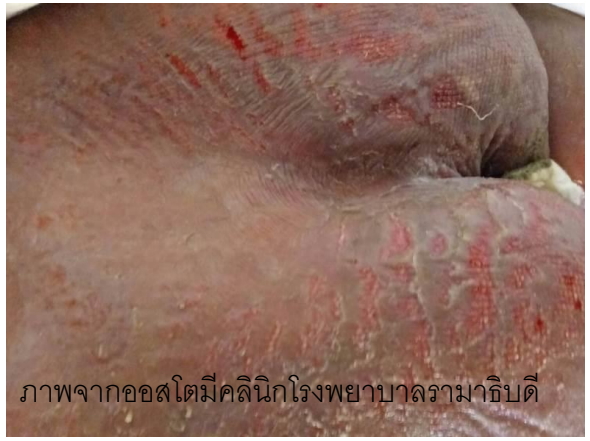
มีแผลกดทับตั้งแต่ระดับ 1 เกิดขึ้นหรือไม่

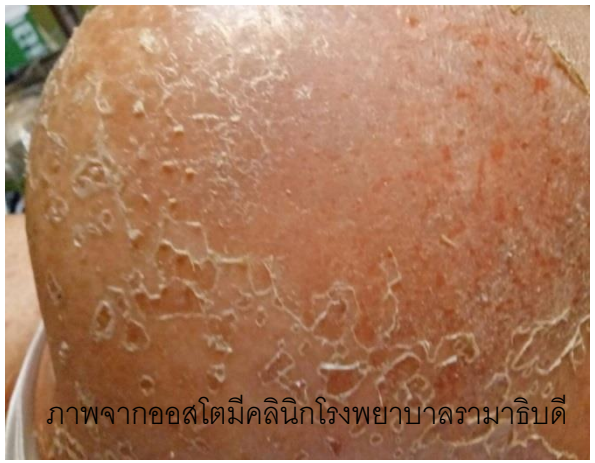
ถ้ามีแผลกดทับที่เกิดใหม่ตั้งแต่ระดับ 1 ขึ้นไป

ผลลัพธ์จากการดูแลแผลกดทับนั้นเป็นอย่างไร

Apply cotton ball กับ Micropore (Slit technique)

รองบริเวณใบหูเพื่อลดแรงกดจาก Face mask





Use All of Your Senses…

- Visual inspection of the skin is NOT enough
  - Look, listen (to patient and family)
- Touch / palpate skin and adjoining area
- Use of a pen light can assist with skin color change observations
- Early detection of at risk patients should be high priority
- Erythema and/or blanching are not reliable indicators of skin compromise in darker skinned individuals

การประเมินผู้ป่วย โดยใช้แบบประเมิน

ใครประเมิน

ประเมินเมื่อไร

ประเมินทุกกี่วัน

ประเมินแล้วบอกใคร

หลักฐานการประเมิน

การวางแผนการพยาบาลเมื่อรู้ระดับความเสี่ยง

หากมีแผลจะรู้ได้อย่างไรว่าเป็นแผลระดับไหน

จากการดูแลแผลดีขึ้นหรือแย่ลง

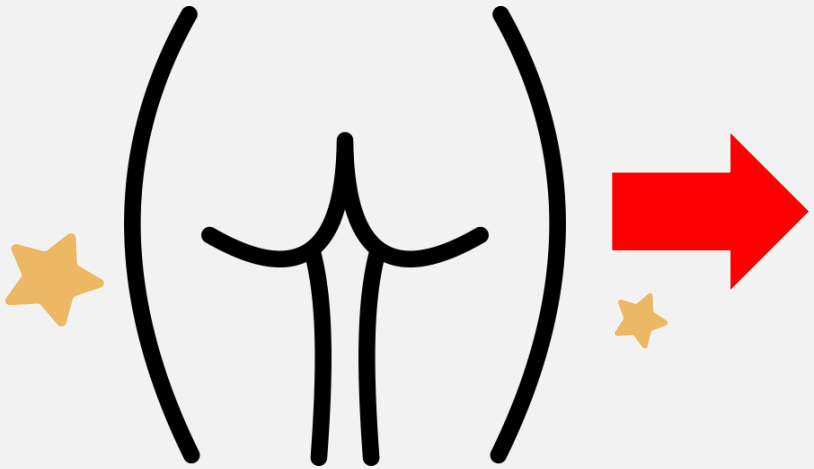
ถ้าแผลแย่ลงมีคำตอบไหมว่าสาเหตุจากอะไร

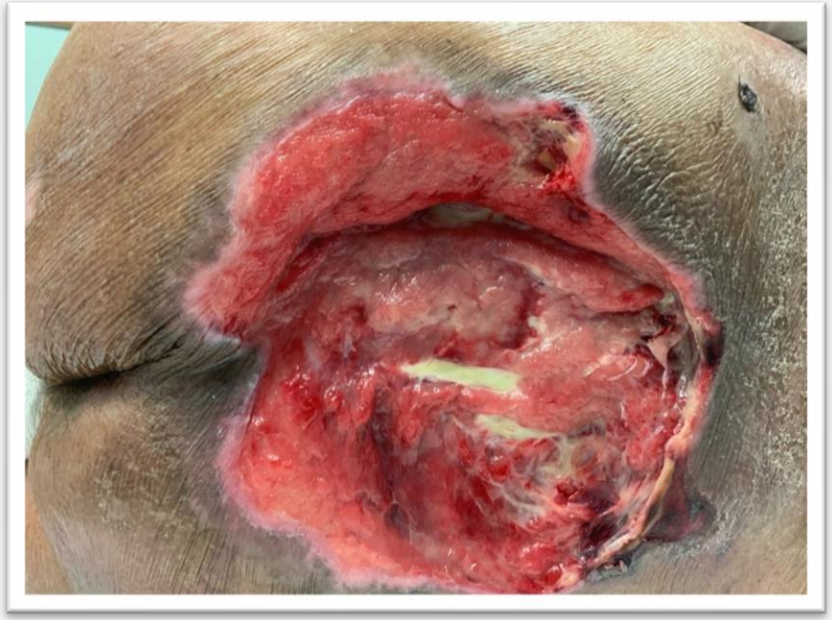
สิ่งที่ส่งผลลัพธ์ต่อการบริการพยาบาลของเรา คือ

- ไม่เกิด สุดยอด
- เกิด แผลหาย หรือแผลดีขึ้น

Goals of Comprehensive Skin Assessment

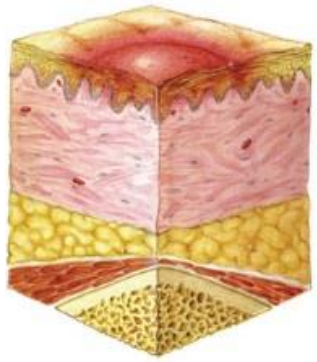
- Identify any pressure injury.
- Find out if there are other lesions or skin related factors that predispose the patient to develop pressure injury.



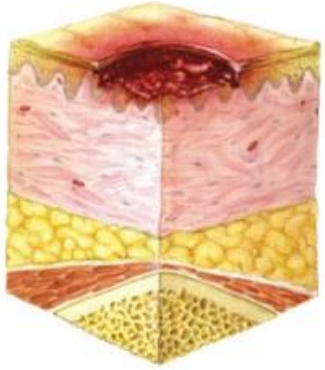


PRESSURE INJURY

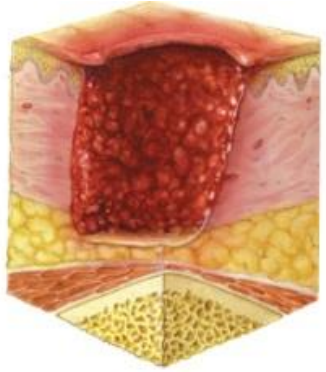
Skin and soft tissue assessment is a key component of pressure inj prevention, classification, diagnosis, and treatment.



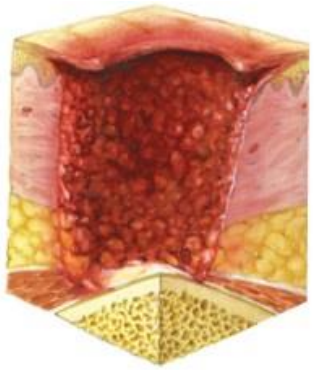
Stage 1



Stage 2

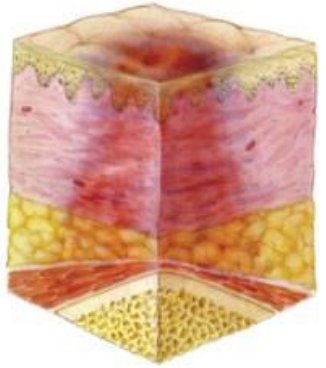


Stage 3

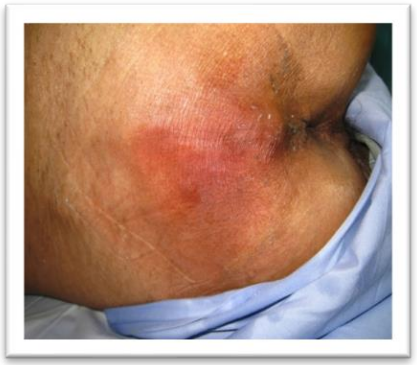


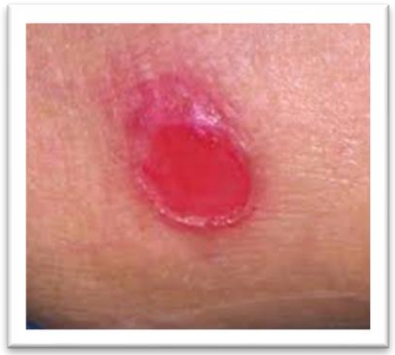
Stage 4

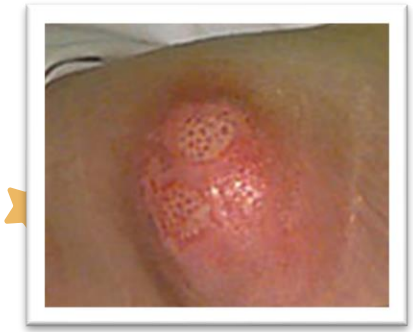
Unstageable

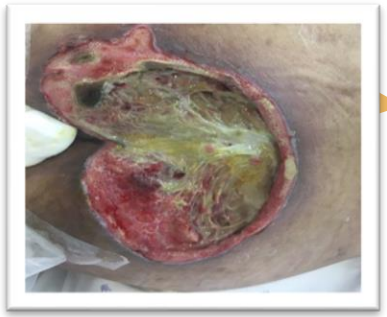


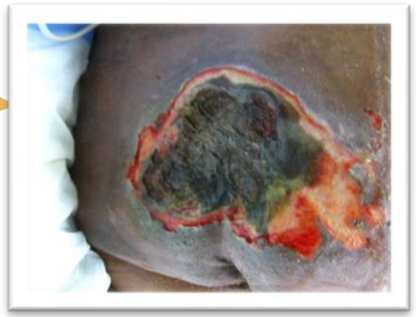
Suspected Deep Tissue Injury

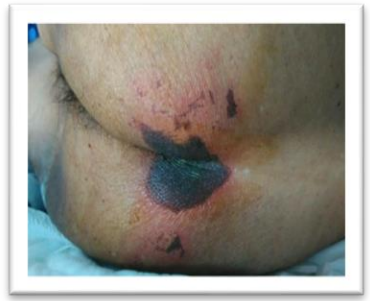


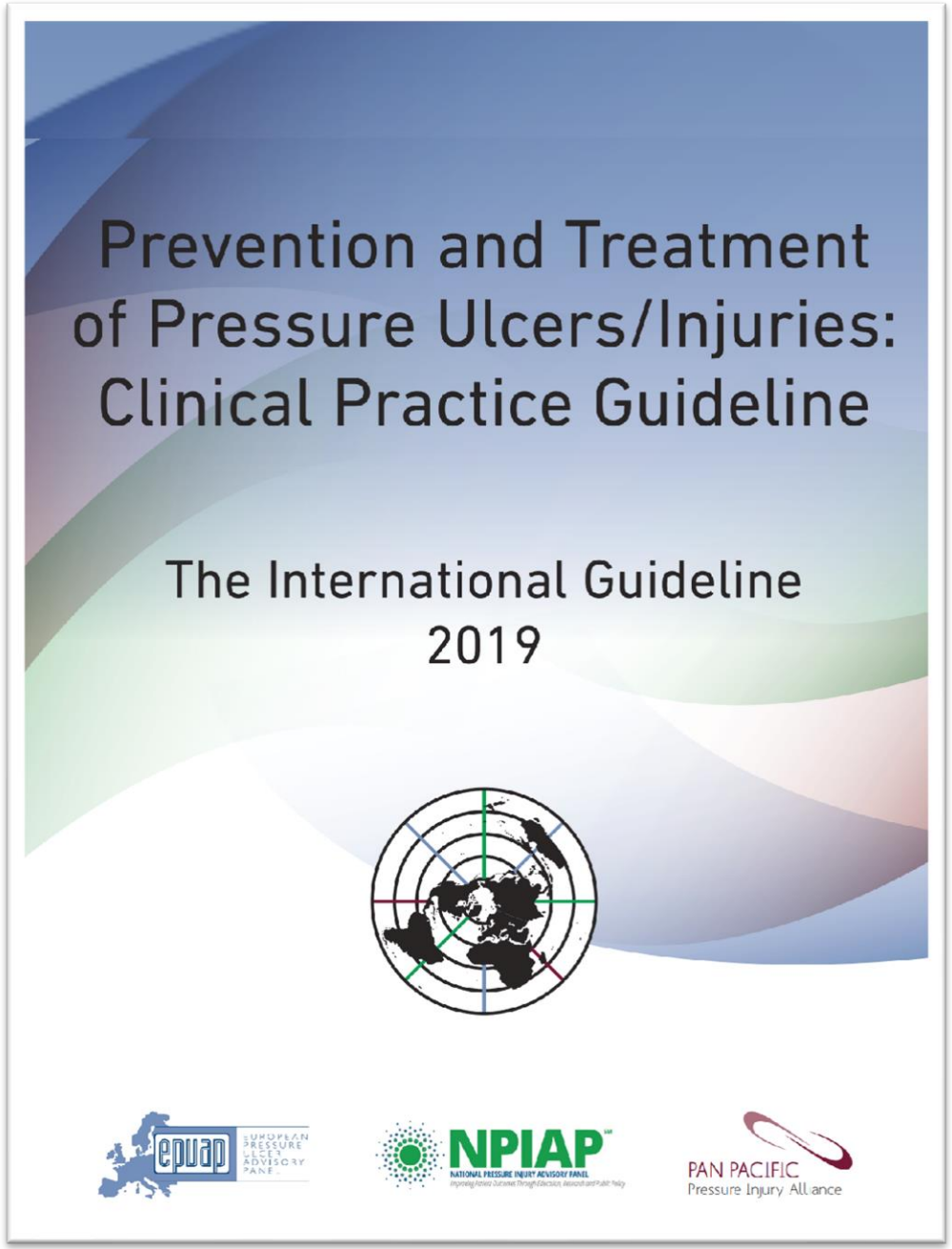












สมาคมพยาบาลแผล ออสโตมี และควบคุมการขับถ่าย
ET NURSE
Enterostomal Therapy Nurse Association

Prevention of Pressure Injuries

Risk Factors and Risk Assessment .....

Skin and Tissue Assessment .....

Preventive Skin Care .....

Kottner, J., Cuddigan, J., Carville, K., Balzer, K., Berlowitz, D., Law, S., ... & Haesler, E. (2019). Prevention and treatment of pressure ulcers/injuries: The protocol for the second update of the international Clinical Practice Guideline 2019. *Journal of tissue viability*, *28*(2), 51-58.

Conducting Skin and Tissue Assessment

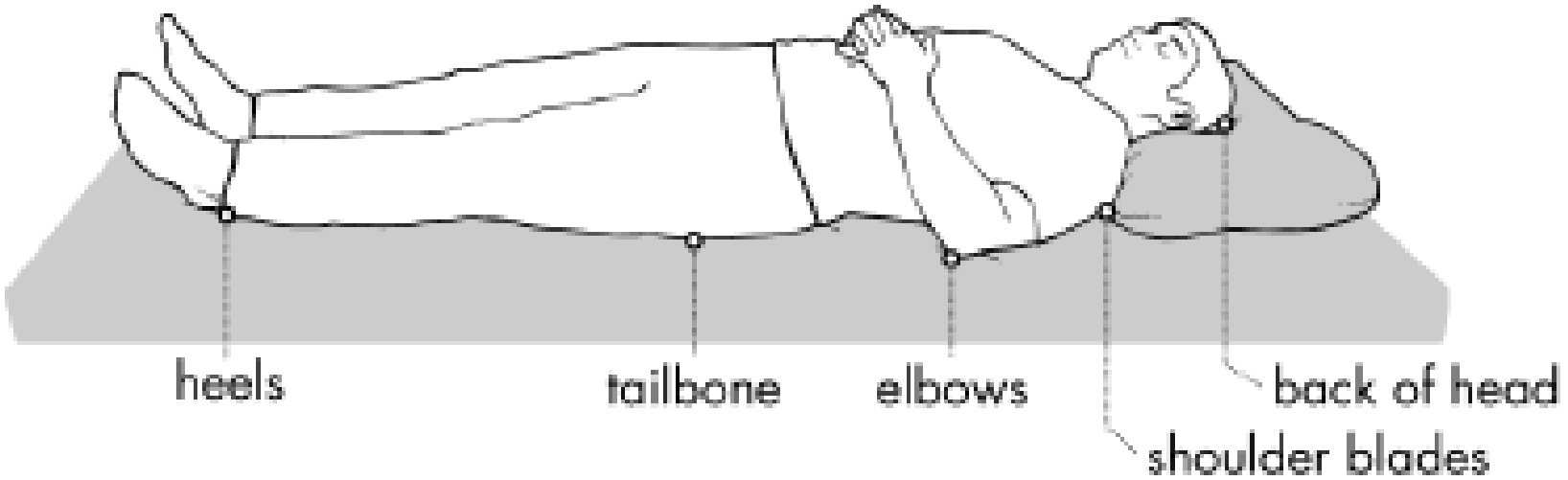
2.1: Conduct a comprehensive skin and tissue assessment for all individuals at risk of pressure injuries:

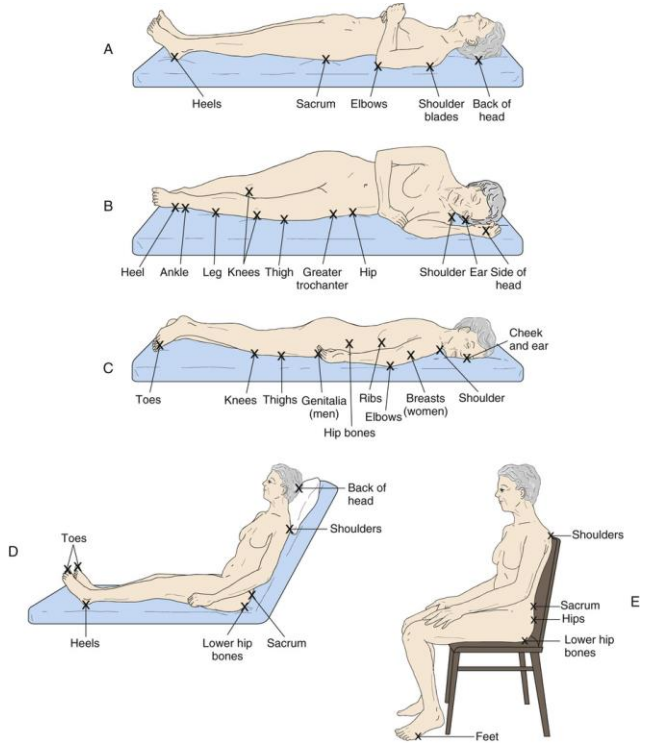
- As soon as possible after admission/transfer to the healthcare service
- As a part of every risk assessment
- Periodically as indicated by the individual's degree of pressure injury risk
- Prior to discharge from the care service.

(Good Practice Statement)

Implementation Considerations

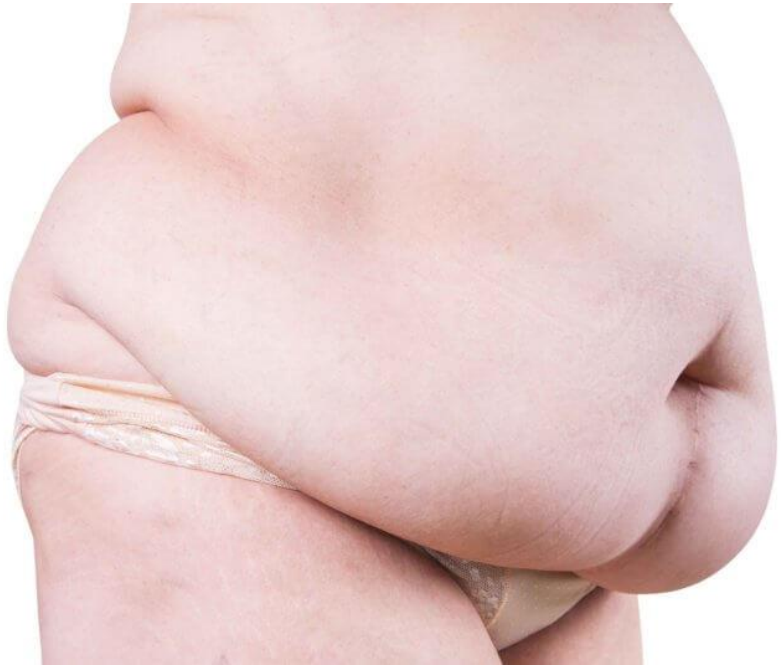
- **Skin inspection should be a high priority and performed as soon as possible following admission to a healthcare service (*Expert opinion*).**
- At the organizational level, ensure that a complete skin assessment is part of the risk assessment screening policy in the care service (*Expert opinion*).
- Conduct a head-to-toe assessment with particular focus on skin overlying bony prominences, including the sacrum, heels, hip, pubis, thighs and torso.[3,4] Include the occiput in a head-to-toe skin assessment for neonates and young children (*Expert opinion*).

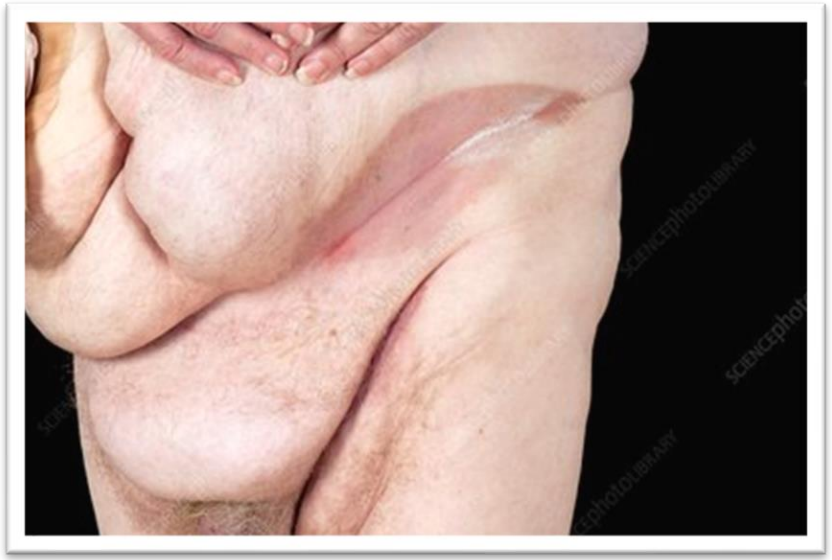




Implementation Considerations

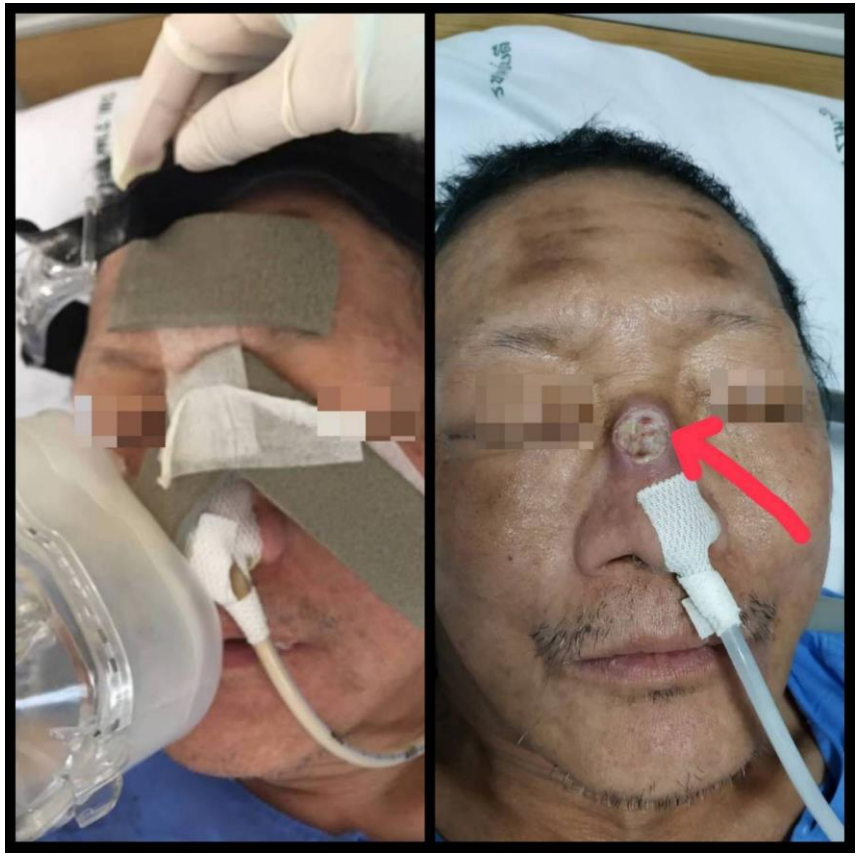
- Assess the skin for signs of maceration, paying attention to skin folds, especially in individuals who have obesity (*Expert opinion*).



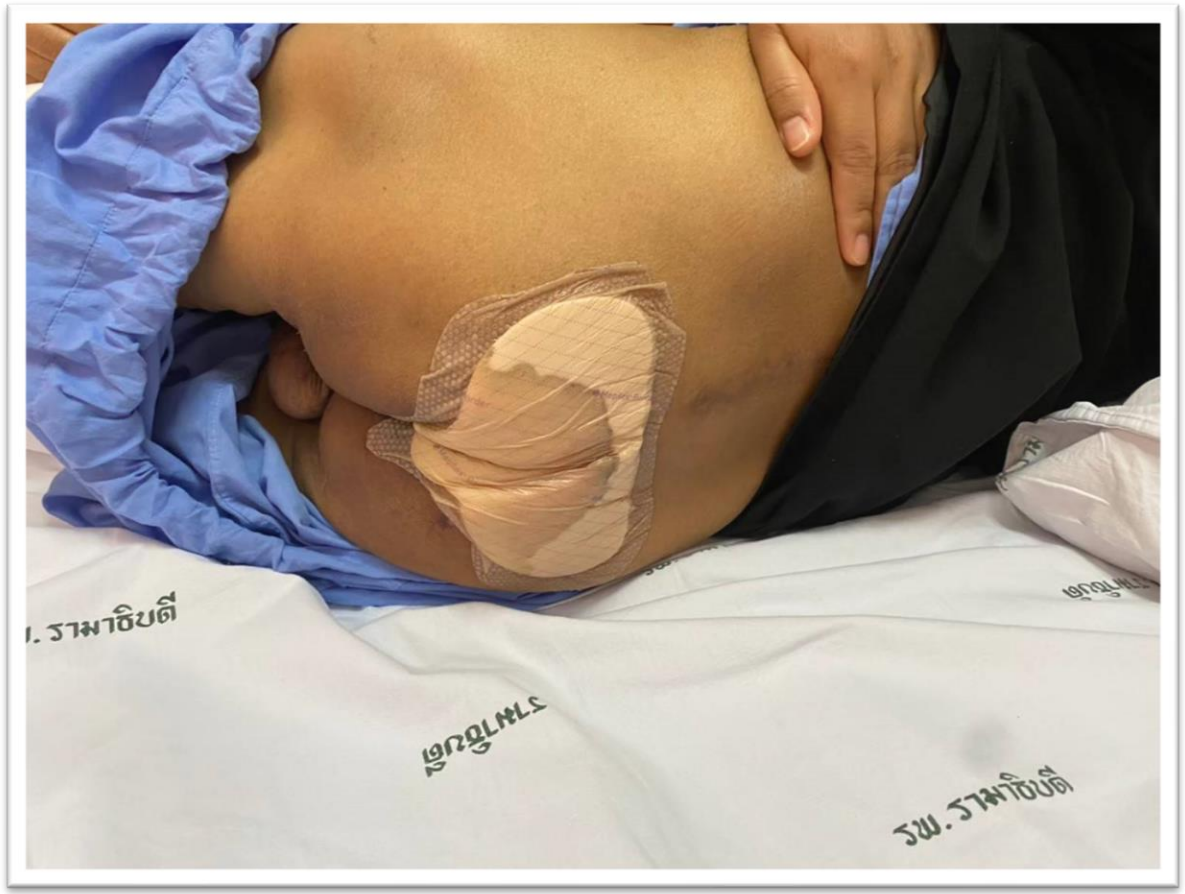


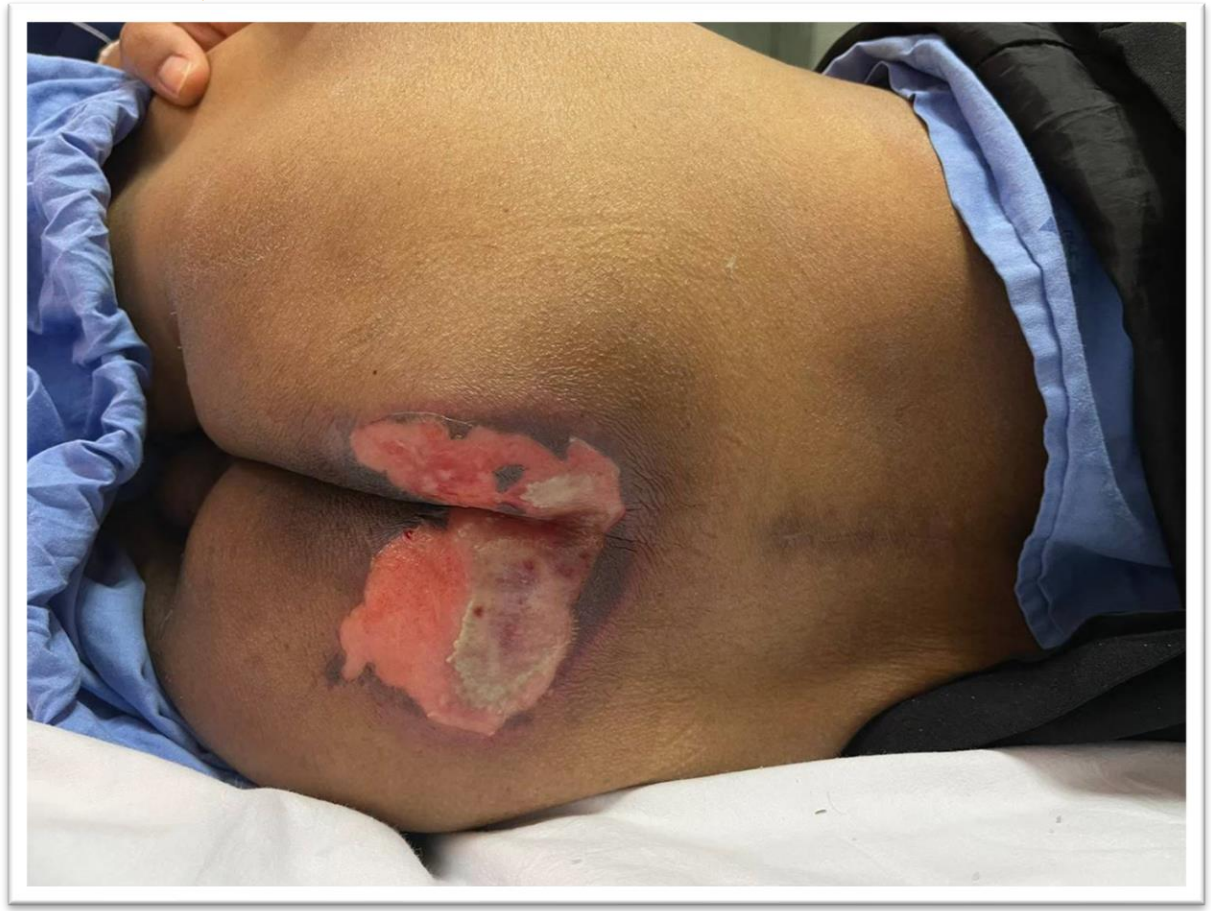
Implementation Considerations

- Inspect the skin for erythema before repositioning. Avoid positioning the individual on an area of erythema wherever possible (*Expert opinion*).
- Assess the skin and soft tissues underneath medical devices as a part of routine skin assessment (*Expert opinion*). See the guideline chapter on *Device Related Pressure Injuries* for more information about assessing skin under and around devices



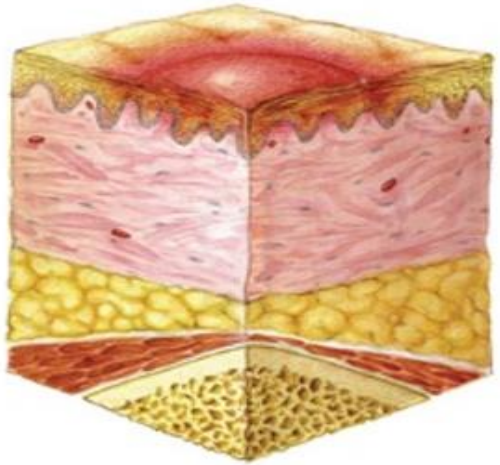
Routine skin assessment



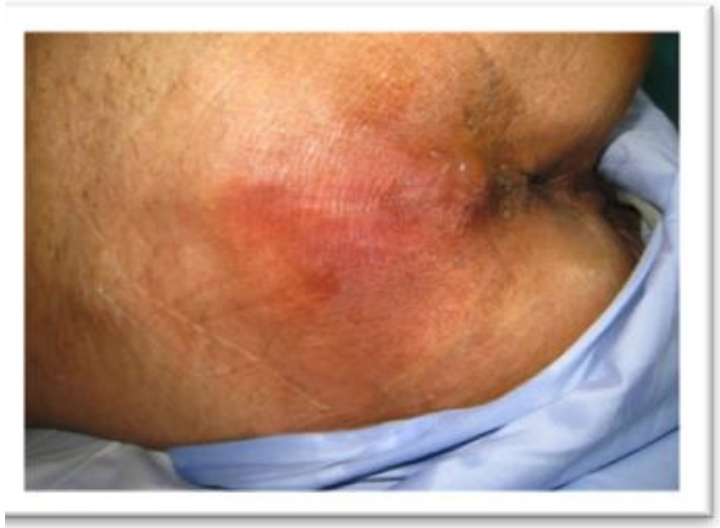


2.2: Inspect the skin of individuals at risk of pressure injuries to identify presence of erythema.
(Strength of Evidence = A; Strength of Recommendation = ↑↑)

2.3: Differentiate blanchable from non-blanchable erythema using either finger pressure or the transparent disk method and evaluate the extent of erythema.
(Strength of Evidence = B1; Strength of Recommendation = ↑↑)



Stage 1



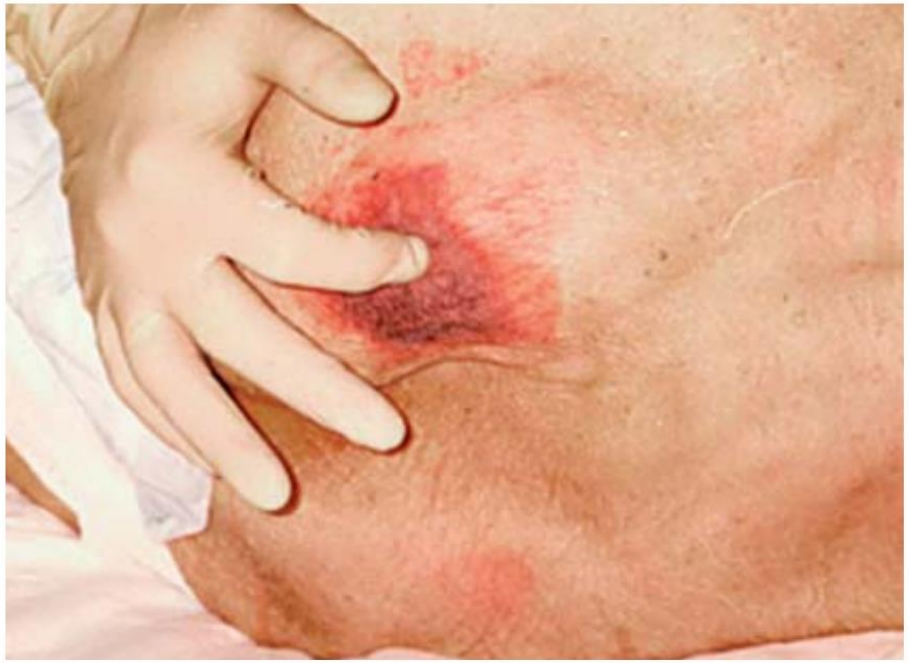
2.4: Assess the temperature of skin and soft tissue.
(Strength of Evidence = B1; Strength of Recommendation = ↑)

Implementation Considerations

- Inspection of the skin should include a visual inspection in conjuction with other skin assessment techniques such as touch and palpation for differences in temperature and tissue consistency[26] (*Level 2*).
- Ensure adequate tangential lighting during visual inspection of the skin[26] (*Level 2*).
- To perform the finger pressure method, a finger is pressed on the erythema for three seconds and blanching is assessed following removal of the finger on intact skin[23,25] (*Levels 2 and 4*).
- To perform the transparent disk method, a transparent disk is used to apply pressure equally over an area of erythema and blanching can be observed underneath the disk during its application[23,25] (*Levels 2 and 4*).
- If there is difficulty in differentiating between a Category/Stage I pressure injury and reactive hyperemia, relieve the pressure area for 30 minutes, then repeat the skin inspection (*Expert opinion*).
- Large skin areas require several measurement points (*Expert opinion*).
- Document the findings of all skin assessments (*Expert opinion*).
- It is not always possible to identify erythema on darkly pigmented skin (*Expert opinion*). Further guidance on assessing darkly pigmented skin in which detection of erythema is more difficult is provided throughout this chapter.

2.5: Assess edema and assess for change in tissue consistency in relation to surrounding tissues.
(Good Practice Statement)

2.6: Consider using a sub-epidermal moisture/edema measurement device as an adjunct to routine clinical skin assessment.
(Strength of Evidence = B2; Strength of Recommendation = ↔)



Anders, J., Heinemann, A., Leffmann, C., Leutenegger, M., Pröfener, F., & von Renteln-Kruse, W. (2010). Decubitus ulcers: pathophysiology and primary prevention. *Deutsches Ärzteblatt International*, *107*(21), 371.

Implementation Considerations

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- Provide health professionals with education and experience in assessing edema and changes in skin consistency with the hand to increase their skills in identifying clinically significant changes[26] (*Level 2*).
- Health professionals require training in using a device that measures SEM/edema to facilitate consistency in measurement method over time and between users (*Expert opinion*).

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CONCLUSION

SKIN INSPECTION are Requires looking at and touching skin from “head to toe”

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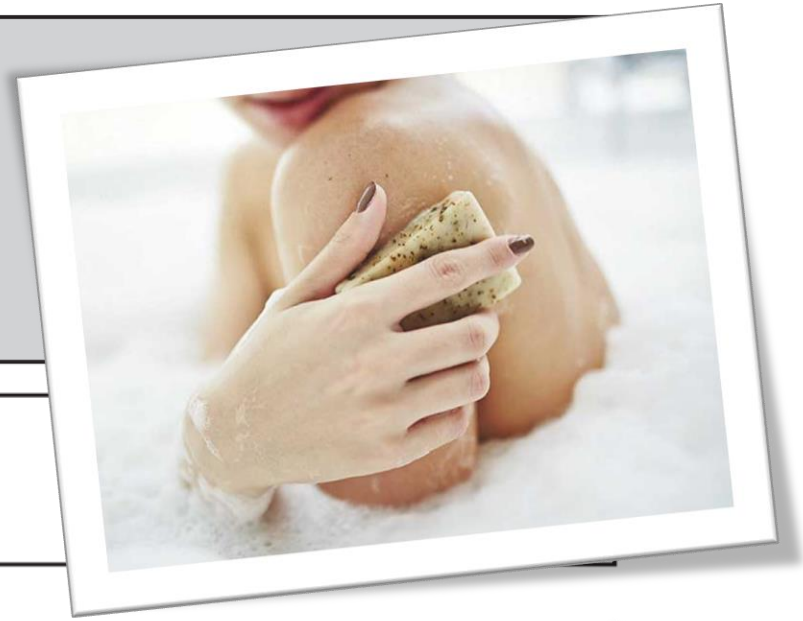
PREVENTIVE SKIN CARE

Skin Hygiene

3.1: Implement a skin care regimen that includes:
- Keeping the skin clean and appropriately hydrated
- Cleansing the skin promptly after episodes of incontinence
- Avoiding use of alkaline soaps and cleansers
- Protecting the skin from moisture with a barrier product.

(Strength of Evidence = B2; Strength of Recommendation = ↑↑)



3.2: Avoid vigorously rubbing skin that is at risk of pressure injuries.
(Good Practice Statement)

Continence Management

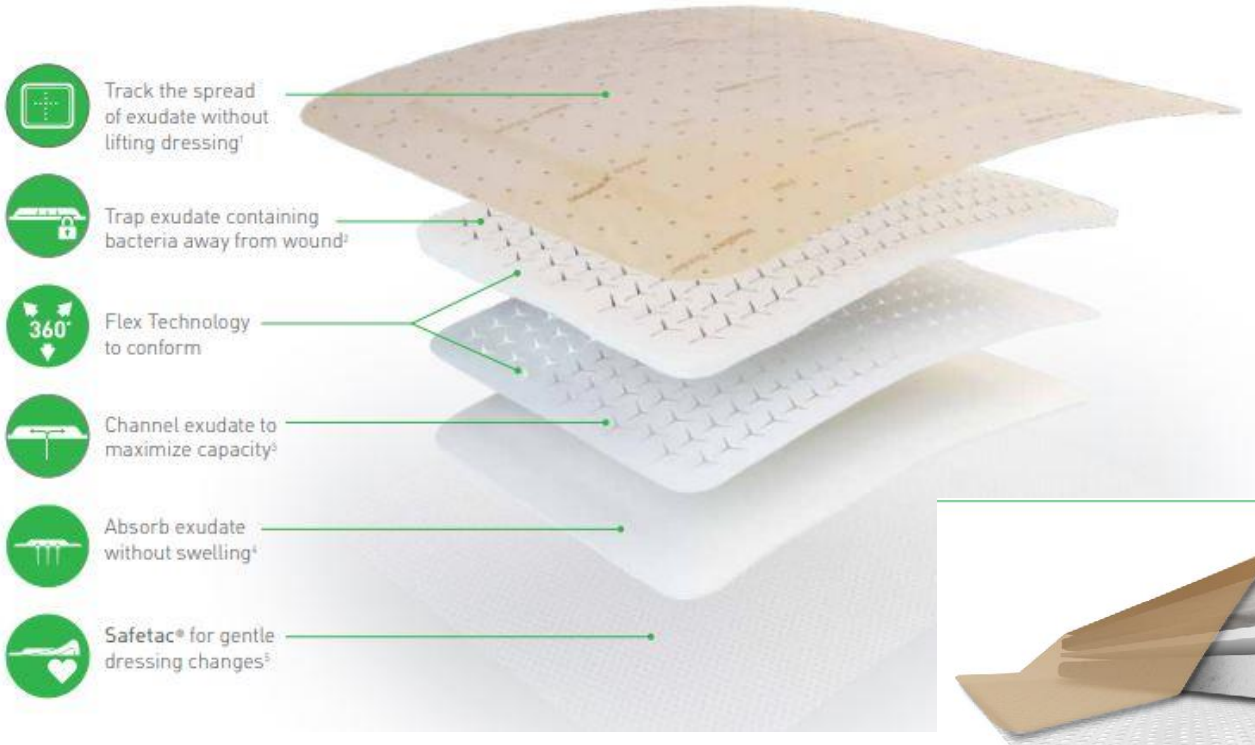
3.3: Use high absorbency incontinence products to protect the skin in individuals with or at risk of pressure injuries who have urinary incontinence.
(Strength of Evidence = B1; Strength of Recommendation = ↑)

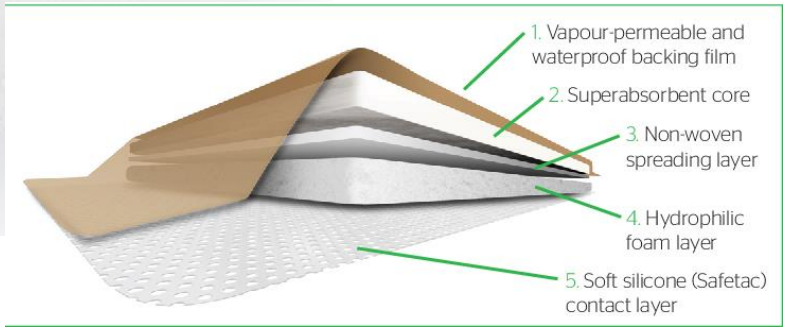
PREVENTIVE SKIN CARE

Bed Linen

3.4: Consider using textiles with low friction coefficients for individuals with or at risk of pressure injuries. (Strength of Evidence = B1; Strength of Recommendation = ↑)

PREVENTIVE SKIN CARE





Prophylactic Dressings

3.5: Use a soft silicone multi-layered foam dressing to protect the skin for individuals at risk of pressure injuries. (Strength of Evidence = B1; Strength of Recommendation = ↑)

THANK YOU
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