SKIN AND WOUND ASSESSMENT

Skin/Integumentary ☐ Normal ☐ Cyanotic ☐ Pale ☐ Jaundice ☐ Dusky ☐ Mottled ☐ Flushed
☐ Clammy ☐ Diaphoretic ☐ Dry ☐ Moist ☐ Scaly ☐ Tenting

Alterations in Skin Document any abrasions, bruising, fungal/yeast infections, MASD, neuropathic/diabetic ulcers, pressure injuries, rashes, skin tears, surgical incisions, vascular ulcers, etc.

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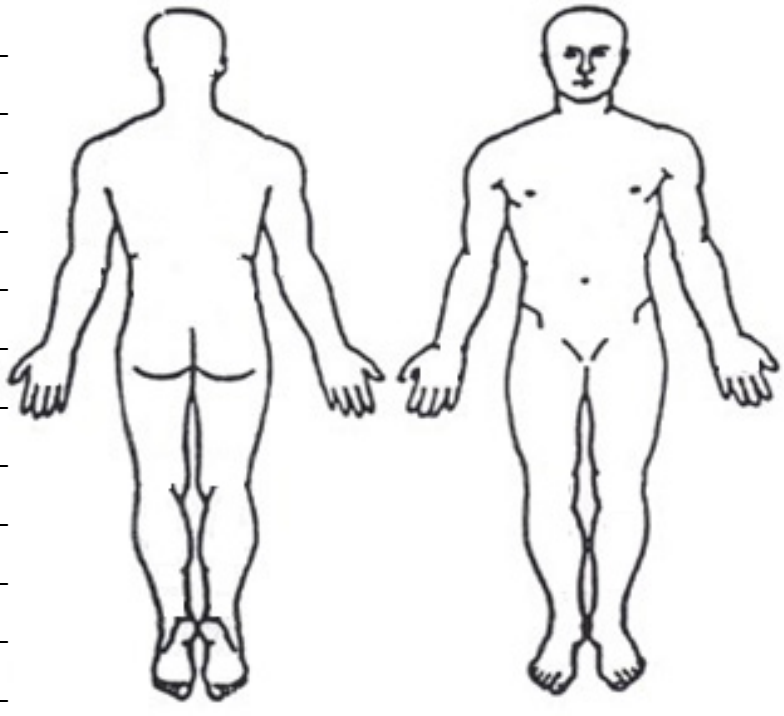
11. _____
12. _____



Braden Scale (summarized)
Sensory Perception (ability to respond to meaningful stimuli):
☐ 1-Completely Limited ☐ 2-Very Limited ☐ 3-Slightly Limited ☐ 4-No Impairment
Moisture (degree to which skin is exposed to moisture)
☐ 1-Constantly Moist ☐ 2-Very Moist ☐ 3-Ocassionaly Moist ☐ 4-Rarely Moist
Activity (physical activity level)
☐ 1-Bedfast ☐ 2-Chairfast ☐ 3-Walks Occasionally ☐ 4-Walks Frequently
Mobility (ability to change and control body position)
☐ 1-Completely Immobile ☐ 2-Very Limited ☐ 3-Slightly Limited ☐ 4-No Limitations
Nutrition (usual eating pattern)
☐ 1-Very Poor ☐ 2-Probably Inadequate ☐ 3-Adequate ☐ 4-Excellent
Friction and Shear (problems r/t friction and shearing)
☐ 1-Problem ☐ 2-Potential Problem ☐ 3-No Apparent Problem
Total Score _____ >18 Not at Risk, 15-18 At Risk, 13-14 Moderate Risk, 10-12 High Risk, <10 Very High Risk

Treatments and Interventions ☐ None
☐ Topical Medications/Ointments ☐ Turning/Repositioning Program ☐ Referral to Wound Nurse or Clinic
☐ Dressing Management ☐ Moisture Management ☐ Pressure Injury Care ☐ Surgical Wound Care
☐ Antimicrobial Dressings/Cleanser ☐ Antibiotics for Infection ☐ Nutrition/Hydration Interventions
☐ Pressure Reducing Device for Bed ☐ Air Mattress/Bed ☐ Pressure Reducing Device for Chair

Notes

Pressure Injury: Localized damage to skin and underlying soft tissue usually over a bony prominence or related to a medical or other device; occurs as results of intense and/or prolonged pressure or pressure in combination with shear.
Stage 1 Pressure Injury: Non-blanchable erythema/redness, intact skin.
Stage 2 Pressure Injury: Partial thickness loss of dermis presenting as shallow open ulcer with red, pink wound bed, without slough; may also present as intact or open serum filled blister.
Stage 3 Pressure Injury: Full thickness tissue loss; subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed; slough may be present but does not obscure depth; may include undermining and tunneling.
Stage 4 Pressure Injury: Full thickness loss with exposed bone, tendon, or muscle; slough or eschar may be present on some parts; often has undermining and tunneling.
Unstageable Pressure Injury: Full thickness tissue loss in which base of ulcer is covered (>50%) by slough and/or eschar.
Deep Tissue Injury (DTI): Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage or underlying soft tissue from pressure and/or shear.
Medical Device Related Pressure Injury: Results from the use of medical devices. The resultant injury generally conforms to the pattern or shape of the device.
Mucosal Pressure Injury: Mucosal pressure injury found on mucous membranes with a history of medical device in use at the location of the injury. Cannot be staged due to the anatomy of tissues.
Moisture Associated Skin Damage: Inflammation and erosion of the skin caused by prolonged exposure to vapors sources of moisture, including urine or stool, perspiration, wound exudate, mucus, or saliva.
Intertriginous (ITD): Perspiration or moisture trapped in skin folds.
Peristomal: Urine, stool, chemical irritants and this with pH extremes, mechanical injury.
Periwound: Wound exudate, varies types of chemical irritants, pH extremes, mechanical injury (point of entry - organisms).
Incontinence Associated Dermatitis (IAD): Urine and stool**.**
Irritant contact dermatitis (ICD): Triggered by exposure to irritant such as rubbing alcohol, bleach, solvents, deodorants, soaps, cosmetics, fragrances, plants; erythema, edema, vesicles; TEWL normalizes in 6-12 days.
Allergic contact dermatitis (ACD): Immune related inflammatory response.
Skin Tear: Traumatic wound caused by mechanical forces.
Type 1 Skin Tear: Skin tear: full thickness; can be fully approximated.
Type 2 Skin Tear: Skin tear: scant, moderate, or large tissue loss.
Type 3 Skin Tear: Skin tear partial thickness wound without epidermal flap present.
Abrasion: Wearing away of the skin through some mechanical process (friction or trauma).
Cellulitis: Painful especially with palpation, progressing erythema, inflammation/warmth, no crusting, port of entry present, unilateral, fever, leukocytosis.
Denuded/Eroded: Skin gone via chemical means (urine, feces, sweat, exudate, etc.).
Dermatitis: Itching, erythema/hyperpigmentation, inflammation, vesicles/crusting/scaling, no port of entry, unilateral/bilateral, no fever, weeping.
Epibole: Rolled or curled under edges, premature closure, often in longstanding wound.
Eschar: Necrotic or non-vital tissue; appearance of leathery black or brown; can be soft, firm, adherent, or loose.
Excoriation: Linear epidermal abrasion caused by scratching.
Fungal/yeast infection: Erythematous, macular/papular, non-follicular pustules and satellite lesions outside advancing edge, maceration, burning and itching.
Laceration: A deep cut or tear.
Lesion: A region in an organ or tissue which has suffered damage through injury or disease, such as ulcer, abscess, or tumor.
Maceration: Softening and breaking down of the skin due to prolonged exposure to moisture. Often appears white of lighter in color than the skin next to it.
Medical Adhesive Related Skin Injury (MARSI): Top down skin injury. Erythema and or other manifestation of cutaneous abnormality persists 30 minutes or more after removal of adhesive dressings and tapes.
Neuropathic/Diabetic Ulcer: Ulcer caused by damage to nerves interfering with communication between brain/spinal cord and lower legs/feet. Plantar aspect of feet. Punched out appearance.
Satellite Lesions: Extensions of red macular-papular rash that appears as red pinpoint papules or pustules nearby or outside the primary rash.
Slough: Consists of avascular (necrotic or non-vital) tissue, serous exudate, bacteria, fibrin, cell debris, intact leukocytes; soft, moist; it may be white, yellow, tan; firm or loosely adherent.
Tunneling: A narrow opening or passage-way that can extend in any direction through sift tissue and result in dead space with potential abscess formation.
Ulcer: Loss of skin with definite edges.
Undermining: The destruction of the underlying tissue surrounds some or all of the wound margins. May extend in one or many directions underneath the wound edges.
Vascular ulcers: Ulcer with acute pain, palpable purpura (raised non-blanchable erythema), typically on lower legs.