

SKIN ASSESSMENT

A comprehensive skin assessment is an integral part of a complete physical examination. It can be used to evaluate your patient's overall health, including their nutritional status, and monitor for changes that could indicate an emerging problem.

A COMPREHENSIVE SKIN ASSESSMENT SHOULD INCLUDE THE FOLLOWING

1

SKIN TEMPERATURE

The temperature of the patient's skin can reveal information about their overall health. A low body temperature may indicate a nutritional deficiency or severe illness. A high body temperature may indicate an infection or inflammation.

Most clinicians use the back rather than the palm of their hand to assess the temperature of a patient's skin.

SKIN TEXTURE

The texture of the patient's skin can be used for assessing their nutritional status as well as for identifying any changes that could indicate an underlying problem. Healthy skin has a smooth, even texture with no rough spots or signs of flaking or scaling.

2

3

SKIN COLOR

A healthy patient will have normal color and tone, but if you notice any changes in the patient's skin color, it may indicate an underlying medical condition. For example, jaundice indicates liver disease, while pale skin could signify anemia or leukemia.

Use an additional light source such as a penlight to illuminate hard to see skin areas such as the heels or sacrum.

SKIN MOISTURE

Check for dryness on your patient's skin by gently pressing your fingers against their back or arm to see how easily they leave impressions behind as they move away from your touch; this test can be used to determine whether there are issues with hydration or even dehydration (which can occur if someone has been vomiting or having diarrhea).

4

Look for water droplets on the skin. Is the skin clammy?

5

SKIN TURGOR

This test involves gently pinching up an area of the patient's skin and then releasing it to see how quickly it springs back into place. If the skin stays up for more than 2 seconds, this can indicate dehydration.

CAPILLARY REFILL TIME

This test involves pressing on the patient's fingernail bed and then quickly releasing it to see how long it takes for the color in their nail bed to return. If this process takes longer than 2 seconds, this can indicate dehydration or poor circulation in general.

6

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Carolyn Jarvis



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Health Assessment in Nursing Janet Weber, Jane Kelley, 2009-10-01 Now in its Fourth Edition Health Assessment in Nursing is a colorful user friendly introductory level health assessment text for RN level students Targeted to ADN and BSN programs this text presumes no prior knowledge of health assessment and is part of a suite that includes Lab Manual to Accompany Health Assessment in Nursing Nurses Handbook of Health Assessment and Weber Kelley s Interactive Nursing Assessment For this edition the COLDDSPA mnemonic which guides students through investigation of symptoms has been revised to show specific applications to content in each chapter A sample application of COLDDSPA is presented at the beginning of each chapter s Nursing History section and another accompanies each case study The Frail Elderly chapter has been streamlined with a stronger focus on the normal variations associated with assessment of elderly clients Includes DVD ROM

Pocket Companion for Physical Examination and Health Assessment Carolyn Jarvis, PhD Apr Cnp, 2015-03-30 Take this nursing handbook into the clinical setting Pocket Companion for Physical Examination Health Assessment 7th Edition makes it fast and easy to look up essential assessment skills and techniques You ll conduct more effective exams by referring to summaries of examination steps normal versus abnormal findings lifespan and multicultural considerations and over 250 full color photos and illustrations Written by well known educator and clinician Carolyn Jarvis this handbook is a perfect clinical tool whether you re a beginner who is learning assessment skills or a practitioner who needs a portable reference Convenient two column format makes it easier to access learn and understand key physical examination skills and findings More than 250 full color illustrations demonstrate examination skills underlying anatomy and physiology and normal and abnormal findings Color coded design helps you easily locate the information you need dividing each body system chapter into major sections anatomy subjective data objective data and abnormal findings Abnormal findings tables help you recognize sort and describe key abnormal findings Summary checklists offer reviews of key examination steps for quick reference Developmental Competence sections highlight content specific to infants children adolescents pregnant women and older adults Spanish language translation chart helps you improve communication with Hispanic patients during the physical examination Cultural Competence sections provide a context for care of multicultural patient groups NEW evidence based guidelines reflect a focus on conducting the most effective qualitative exams NEW content on the Electronic Health Record charting and narrative recording includes examples of how to document assessment findings NEW photos of normal and abnormal findings show the nose mouth throat thorax and pediatric assessment including developmental and cultural variations

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tools required to interpret the physical therapy evaluation and replicate the measurements and tests This text guides students in learning how to utilize case information and documentation furnished by the PT to assist in the follow up treatment

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