PHYSICAL ASSESSMENT: SKIN

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 fingernals 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
- Bichenification, 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.



Skin Assessment Documentation Example

Stacie J. Fruth

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Skin and Wound Care Cathy Thomas Hess, 2008 Completely updated for its Sixth Edition this handbook is the only all in one portable guide to skin and wound care with new chapters on skin care and incontinence important new information on regulations and more than 650 dressings drugs and other products for every type of wound Part I provides detailed guidelines on wound care and prevention and related professional and legal issues Part II features profiles and photographs of over 300 wound care products Part III contains charts of over 300 additional products Appendices include assessment tools and multiple treatment algorithms A manufacturer resource guide with Website listings is included **Nursing Basic** for Clinical Practice Mr. Rohit Manglik, 2024-07-30 Designed for students and novice nurses this text presents essential knowledge and practical skills needed for everyday clinical nursing responsibilities and patient interactions **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 COLDSPA mnemonic which guides students through investigation of symptoms has been revised to show specific applications to content in each chapter A sample application of COLDSPA 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

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