

BASIC SKIN ASSESSMENT

To perform a basic assessment you must, at a minimum, assess the following elements:

TEMPERATURE:

- Normally warm to touch
- Warmer than normal could signal inflammation
- Cooler than normal could signal poor vascularization

COLOR:

- Intensity: paleness may be an indicator of poor circulation
- Normal color tones: light ivory to deep brown, yellow to olive or light pink to dark, ruddy pink
- Hyperpigmentation or hypopigmentation reflect variations in melanin deposits or blood flow

MOISTURE:

- Dry or moist to touch
- Hyperkeratosis (flaking, scales)
- Eczema (endogenous or exogenous)
- Dermatitis, psoriasis, rashes
- Edema

TURGOR:

- Normally returns to its original state quickly
- Slow return to its original shape (dehydration or effects of aging)

INTEGRITY:

- No open areas
- Type of skin injury (Use the appropriate classification system to identify and record injury type)

Used with permission, Baranoski S. Ayello, EA. Skin an essential organ. In Wound Care Essential: Practice Principles