Daily Skin Check
Week 5

Objective To focus your staff on completing skin as assessments on all residents during care in assessment of skin. Special attention needs to be focused on residents with darker skin tones.

First Ask staff how many days their unit has gone without an acquired pressure injury?

a. If zero, ask how many days in the past week have they been without an acquired pressure injuries.
b. Congratulate each successful day!
c. Check that the Pressure Free Zone board is up-to-date.

Review

a. "You Bruise, You Lose" education lesson plan
   i. Need two fruits of contrasting colors, one dark skin and one light skin. (ex. plum/nectarine; green or yellow apple/dark red apple, and banana)
b. The Pressure Points poster and review each tip

Ask

a. What is the biggest barrier to getting skin assessments done on your shift?
b. What can you do differently in your daily routine to identify suspicious skin problems? (possible answers: carry a flashlight if providing care at night, touch areas to assess for redness, heat or coolness, ask resident about skin pain, itching, etc., follow protocol for reporting skin concerns)

Emphasize Direct care staff is our first "eyes" for identifying skin concerns. Look carefully at discolorations on dark skin-toned residents.

Lesson Direct care staff is the first line of defense for early skin damage. Constant inspection of pressure points during routine care is essential. Special attention needed for residents with darker skin tones as damage is not easily seen.

Daily Skin Check

Week 5: Educational Demonstration

You Bruise, You Lose

Objective To educate staff on the challenges of assessing residents with dark skin (African American, Asian, Hispanic, Mexican, American Indian, etc.)

- Ask for two volunteers; hand one of them the plum/red apple and one the yellow/green apple to locate the bruise. The staff member with the yellow apple will immediately identify the bruise. The one with the red apple will have to look carefully, cast a shadow on the apple, or feel to help identify a bruise. If they ask for help, look very hard and make the point of the difficulty you are having finding the bruise.
- When the bruise is found on both apples, ask "what is the difference here?" They should answer skin color/tone.
- Discuss how this compares to your residents. Reinforce special attention is needed with darker skin tones, especially over bony prominences or after times of prolonged sitting or lying. Explain how critical it is to look for discolorations in good light and touch the skin, especially over pressure points to determine thickness or temperature. It is difficult to "see" redness, purple discoloration, or assess blanching in dark skin tones.
- Now pick up the banana and discuss again the ease of identifying the obvious bruises that would need to be reported in a skin assessment. To make the point that you cannot always tell what is under the skin, peel the banana back and "see what's underneath". Remind them that even slight skin tone changes or a "mushy"feeling may indicate tissue damage and needs to be treated. To achieve the best outcome, it is best to identify early before the skin breaks.
- Remember to report what you see! When you see a suspicious area make sure you report it to the nurse. If you have information about how the area may have occurred, make sure you report that, also.

Lesson Daily assessment of skin is essential to maintain skin health. Staff must be extremely observant when assessing residents with darker skin tones for slight discolorations and change in feel and/or appearance of the skin. Remember to report ALL suspicious areas.

Note: Purchase fruit a couple of days before the in-service. You'll need: 1 red apple or plum: buy without any obvious bruises; create one with your finger, a yellow/green apple: can be purchased with bruises, bananas: purchase without serious bruises; create one with your finger. Some bruising on the rim is good to show what is on the outside is not indicative of what is on the inside.

Daily Skin Check

Week 5: Pressure Points

During care, look at your residents' skin every time, with special focus on pressure points.

Color

- Difficult to assess in darker skin tones
  - Red, Purple, Black, Pink
  - Monitor for slight color changes in residents with darker skin tones

Temperature

- Different from the normal for this resident
  - Hot or cold

Skin Condition

- Dry, scaly, peeling skin similar to the texture of an orange peel
- Moist, soft, wrinkled skin
- Edema (swelling)
- Blisters
- Any openings: cracks, scabs, tears, rashes, boils
- "Mushy" feeling to an area

Skin Condition

- Any complaints of pain from lying or sitting during repositioning or touching of the area
- Complaints of itchy areas, especially over bony prominences

Report any suspicious areas!