14.6: Checklist for Integumentary Assessment

Use this checklist to review the steps for completion of an “Integumentary Assessment.”

Steps

Disclaimer: Always review and follow agency policy regarding this specific skill.

1. Gather supplies: penlight, nonsterile gloves, magnifying glass (optional), and wound measuring tool (optional).
2. Perform safety steps:
   - Perform hand hygiene.
   - Check the room for transmission-based precautions.
   - Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.
   - Confirm patient ID using two patient identifiers (e.g., name and date of birth).
   - Explain the process to the patient and ask if they have any questions.
   - Be organized and systematic.
   - Use appropriate listening and questioning skills.
   - Listen and attend to patient cues.
   - Ensure the patient’s privacy and dignity.
   - Assess ABCs.
3. Ask the patient if they have any known skin conditions or concerns.
4. Inspect the general color of the skin and look for any discolorations. Inspect the skin for lesions, bruising, edema, or rashes.
5. Verbalize the ABCE format for evaluating skin lesions.
6. Inspect the scalp for lesions and hair for lice or nits.
7. Inspect the nail beds for color and palpate for capillary refill.
8. Palpate the skin to assess for temperature, moisture, and turgor. Apply gloves prior to palpation as indicated.
9. Assess pressure points for skin breakdown: back of head, ears, elbows, sacrum, and heels.
10. Palpate for edema on lower extremities bilaterally. If edema is present, determine the grade of edema.
11. Assist the patient to a comfortable position, ask if they have any questions, and thank them for their time.
12. Ensure safety measures when leaving the room:
   ◦ CALL LIGHT: Within reach
   ◦ BED: Low and locked (in lowest position and brakes on)
   ◦ SIDE RAILS: Secured
   ◦ TABLE: Within reach
   ◦ ROOM: Risk-free for falls (scan room and clear any obstacles)
13. Perform hand hygiene.