

## A Guide to Device Skin Inspection

### How to Use this Guide:

1. Determine which device(s) your patient has.
2. Search below for the device & information on how to complete the device-related skin inspection(s).

### 1. Head to Toe Skin Inspection Process (Head to Toe-Front to Back)

#### a. Head/Face:

- i. Common devices seen on head/face include Halos, Glasses, Oxygen Masks, Bi-PAP/CPAP Mask, Nasal Cannula, Highflow Oxytube, Forehead Oxyprobe, NG/NJ tube, Nasal Bridle, & Hearing Aids.

#### ii. **Process:**

1. Remove device(s) if able during skin assessment.
2. Head inspection includes:
  - a. Check behind the head for any skin breakdown.
  - b. Ear inspection includes checking the inner and outer surfaces as well as behind the ear. Use flashlight if necessary.
  - c. Nasal inspection includes using a flashlight to check all surfaces of each nostril (top, bottom, sides, and inside; spreading nares apart if needed) and bridge of nose.
    - i. If any redness or breakdown related to respiratory device, call RT and ask for a different solution:
      1. If redness behind ears, add Oxyears. If redness continues switch from OxyEars to Tender Grip.
      2. If redness inside nares consult with RT to switch oxygen delivery system (e.g. nasal hood).
    - ii. If any redness or breakdown related to bridle or feeding tube contact SWAT RN for assistance.
  - d. Check skin surfaces where straps/tubing from devices may contact skin.
3. If patient has a halo check around pin sites.
4. Reposition device(s) ensuring proper placement.

#### b. Neck:

- i. Common Devices: Cervical collar, Trach, & Trach ties (Posterior neck).

#### ii. **Process:**

1. Remove device(s) if able.
2. Neck inspection includes inspecting the full circumference of the patient's neck.
3. Cervical Collar Inspection:
  - a. Refer to C-Collar Standard work:
    - i. Removal and Placement of Aspen Cervical Collar.
    - ii. Removal and Placement of Miami J Cervical Collar.
      1. Assess collar bones and under chin for redness.
4. Trach Inspection:
  - a. Refer to Tracheostomy and Tracheostomy Ties Skin Inspection Standard work

- b. Check at 6 & 12 o'clock position for all trachs
    - i. For Bivona also check the 4 to 8 o'clock position of tie securement location
  - c. Check posterior neck to ensure 1 finger width between skin and trach ties
5. Reposition device(s) ensuring proper placement.

c. **Chest/Back/Trunk:**

i. Common Devices: Halo Vest, Thoracolumbosacral Orthosis (TLSO), Chest Tube, Device Tubing & Drains

ii. ***Process:***

1. Remove device(s) if able.
  - a. Halo:
    - i. The skin under vest must be inspected every shift by log-rolling the patient to their side and visualizing the skin using a flashlight.
      1. Check shoulders, scapulae, and hips if sitting in chair.
    - ii. If you are not able to visualize the skin under the vest, contact the orthoptist for an individual plan for patient skin inspection.
      1. If an orthoptist is not assigned, contact neurosurgeon.
    - iii. Refer to the Lippincott's procedure: [Halo Vest Skin Care](#) as needed.
2. Check all areas of back, chest, and trunk including under breasts, skin folds, and over any bony prominences.
3. Turn patient to their side to check the entire backside, focusing attention at any tube insertion sites or where tubing lays on the skin.
4. Reposition device(s) ensuring proper placement.

d. **Upper Extremities:**

i. Common Devices: Casts, Splints, Oximeter probes, Ace Wrap, BP Cuff, Restraints, & Jewelry (Watches/Rings)

ii. ***Process:***

1. Remove device(s) if able.
2. Inspect the armpit area paying close attention when TLSO in use.
  - a. Have patient lift arms if able, assist if necessary.
3. Assess elbow on each arm. If elbow protector in place remove protector; these should not be used at Bethesda.
4. Finger inspection:
  - a. Spread fingers apart to clearly identify any pressure points on the fingers. Make sure to look closely at all areas of skin where jewelry, e.g. rings, are touching.
  - b. If oximeter probe in use and patient has a trach or scheduled treatments RT will check the oximeter probe every 8 hours. RT will notify RN with any abnormal findings.
    - i. If oximeter probe in use and patient doesn't have a trach or scheduled treatments the nurse needs to check under the oximeter probe every shift.
5. Inspect all arm/hand skin surfaces that were in contact with a device.
6. Non-removable cast, per Lippincott's procedure [Cast Assessment and Management](#):
  - a. Check to see that the cast isn't too tight by running your finger inside the cast. A well-fitted cast has about a finger's width of clearance between the cast and the skin.
  - b. Assess skin areas around the cast's edges for irritation, rash, and skin breakdown, which can be caused by pressure on the edges of the cast.
7. Restraints:

- a. Complete the skin checks per policy [HENSA R3 Use of Restraint and Seclusion](#).
  8. Reposition any device(s) ensuring proper placement.
- e. **Abdomen:**
- i. Common Devices: Abdominal Binder, Feeding Tubes, Buttons/T-Fastener, Ostomies, Drains, Device Tubing, & Retention Sutures.
  - ii. ***Process:***
    1. Remove device(s) if able.
    2. Check under all skin folds to ensure tubing is not located within fold.
      - a. Lift up the skin and look for any redness or breakdown.
    3. Feeding tube:
      - a. Check the skin around the tube including checking under the external bumper.
      - b. If dressing in place remove dressing to assess skin. Apply new dressing following skin assessment.
    4. Ostomy:
      - a. Check ostomy clip for any skin breakdown.
    5. Reposition device(s) ensuring proper placement.
      - a. Ensure that tubing is not causing pressure if located under other device(s) or within skin folds e.g. TLSO or Halo causing pressure on feeding tube, feeding tube causing pressure on button.
- f. **Buttock/Coccyx/Perineal area:**
- i. Common Devices: Rectal Tube, Foley, Rectal Pouch, Device Tubing & Incontinent Garment.
  - ii. ***Process:***
    1. Remove device(s) if able.
    2. Turn patient onto their side to fully visualize the backside.
    3. Rectal Tube:
      - a. Gently spread buttocks apart for visualization. Check anal opening by completing a 360° assessment, especially at the 6 to 9 o'clock position.
    4. Foley Catheter:
      - a. Check insertion site, then follow the tube down the skin to check under the tube. Check inner thigh to posterior thigh.
      - b. Be sure Foley is placed appropriately on the bed, not lying on the floor or tubing too taut.
        - i. Use [STATLOCK® Foley Stabilization Device](#) or leg strap unless otherwise directed by WOC.
          1. For proper placement of stabilization device refer to [STATLOCK® Foley Stabilization Device](#) or [Indwelling urinary catheter \(Foley\) care and management](#).
          2. Abdomen is an alternative site for [STATLOCK® Foley Stabilization Device](#).
    5. Incontinent garment:
      - a. Remove garment for skin assessment ensuring no tubes are causing pressure.
    6. Reposition device(s) ensuring proper placement.
- g. **Lower Extremities:**
- i. Common Devices: Device Tubing, CAM Boot, Anti-Embolism Devices, Foley Stabilization Device, Stump Protector, Juxtacure, Restraints, Cast, Prosthesis, Braces, Heel Off-loading Device, Slippers/Socks, Oximeter Probe, Ace Wrap, & Shoes.
  - ii. ***Process:***

1. Remove device(s) if able including slippers/socks/shoes.
2. Non-removable cast, per Lippincott's procedure [Cast Assessment and Management](#):
  - a. Check to see that the cast isn't too tight by running your finger inside the cast. A well-fitted cast has about a finger's width of clearance between the cast and the skin.
  - b. Assess skin areas around the cast's edges for irritation, rash, and skin breakdown, which can be caused by pressure on the edges of the cast.
3. Restraints:
  - a. Complete the skin checks per policy [HENSA R3 Use of Restraint and Seclusion](#).
4. Heels:
  - a. When inspecting the back of the heel it is easier to visualize when patient is on their side. It is easier to visualize the side of the heel when you are standing at the end of the bed
  - b. You can also use a mirror for better visualization.
5. Toes:
  - a. Gently spread toes apart to visualize all sides of each toe.
6. Oximeter Probe on toe:
  - a. RT will check the oximeter probe every 8 hours for patients with a trach or scheduled treatment and notify RN with any abnormal findings.
  - b. The nurse needs to check the oximeter probe every shift if patient does not have trach or scheduled treatments.
7. Reposition device(s) ensuring proper placement.
  - a. Ensure tubing is not causing pressure under device(s) e.g. if SCD's in use make sure Rooke boot isn't causing pressure to SCD causing injury to skin.



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