The impact of the environment must also be considered as skin assessment often takes place inside a building using artificial rather than natural lighting – fluorescent lighting causing altered hues on the skin.

IDENTIFYING THE FIRST STAGES OF PRESSURE DAMAGE IN DARK SKIN

There has been debate about the best way to assess dark pigmented skin for early signs of pressure damage and much of this discussion followed a task force set up by the NPUAP (Bennett, 1995). The task force’s major recommendations are summarised in Box 2.

Many of the recommended steps involve looking for skin colour changes other than redness, or direct contact between the caregiver’s hand and the patient’s skin to locate areas that feel warmer, cooler or harder than the surrounding skin. These visual or tactile changes may still be difficult to identify as early stages of pressure damage. Two of the suggested indicators are induration (hardness) and oedema.

However, induration may be difficult to distinguish from dryness and many older people have gravitational oedema, making identification of swelling caused by the inflammatory response to pressure difficult to achieve. Identifying skin temperature change may be a challenge, for instance patients’ skin following repositioning in bed is likely to be warm because of their previous dependent position. In this situation it is advisable to recheck for temperature changes after 30 minutes has passed (although in clinical practice nurses may not remember or have time to do this). If the patient is pyrexial this may be reflected in the skin and mask localised temperature changes.

Attention needs to be paid to reports of pain and discomfort associated with body areas that bear load while the patient is in bed or seated (NPUAP and EPUAP, 2009). However, people with sensory neuropathy may not experience the pain caused by pressure damage. Older patients may have generalised pain due to inflammatory conditions such as arthritis and separating this from local pain may be beyond the remit of the validated pain tools used in clinical practice. In addition the use of analgesia for systemic conditions may mask localised pain.

Detecting early pressure damage is not the sole responsibility of healthcare professionals and educating patients and carers to help them recognise the initial signs of damage, regardless of skin colour, can be a valuable investment in a pressure ulcer prevention programme.

FUTURE DEVELOPMENTS

In the future assessing dark pigmented skin may be improved with wound imaging. Springle et al (2009) reported results of their early work using wound imaging to improve the identification of early skin changes related to pressure damage. Using light and dark pigmented volunteers, identification of erythema was accurate in more than 90% of cases. This gives some hope that future assessment of skin changes will be facilitated by using technology in the same way that Doppler ultrasound has helped the diagnosis of leg ulcer aetiology.

CONCLUSION

Assessing for early signs of pressure damage in people who have dark pigmented skin is challenging and there is no simple solution to the problem. Nurses need to use their observation skills and holistic assessment to ensure that any signs of pressure damage are detected and managed quickly. Technological advances may offer a solution to this challenging problem in the future.

REFERENCES


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