King Saud University
College of Nursing
Medical Surgical Department

NUR 221 (PRACTICAL)

PROCEDURE GUIDE AND PERFORMANCE CHECKLIST

MODULE 2
Skin, Hair and Nail Assessment

PHYSICAL ASSESSMENT

- **Physical assessment of the skin, hair and nails requires the use of inspection and palpation in an organized pattern. When lesions are present, measurements are used to identify the size of the lesions and location in relation to accepted landmarks.**

EQUIPMENT

- Examination gown and drape
- Examination light
- Examination gloves, clean and nonsterile
- Centimeter ruler
- Magnifying glass
- Penlight

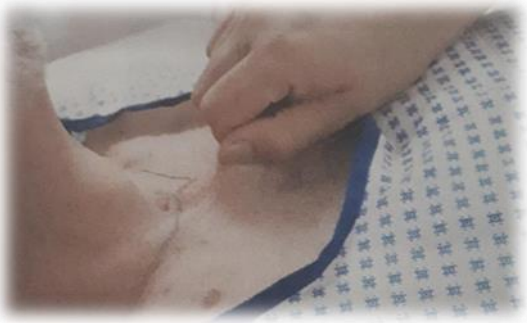
Preparation guidelines:

- Provide a warm, private environment to reduce patient anxiety.
- Provide special instructions and explain the purpose for removal of clothing, jewelry, hairpieces, nail enamel.
- Maintain the patient's dignity by using draping techniques.
- Monitor one's verbal responses to skin conditions that already threaten the patient's self-image.
- Be sensitive to cultural issues. In some cultures touching or examination by members of the opposite sex is prohibited.
- Covering the head, hair, face, or skin may be part of religious or cultural beliefs. Provide careful explanations regarding the need to expose those areas for assessment.
- Direct sunlight is best for assessment of the skin, if it is not available, lighting must be strong and direct. Tangential lighting may be helpful in assessment of dark-skinned patients.
- Use Standard Precautions throughout the assessment.
- Obtain Health History.
- Conduct complete physical examination.
    - Know the person's normal skin coloring.
    - Begin by examining hands and fingernails to accustom the client for touching.
    - Pay attention for areas with skin folds.
    - Stand back to get an overall impression and notice patterns of lesions.
    - Assess the skin as one entity.

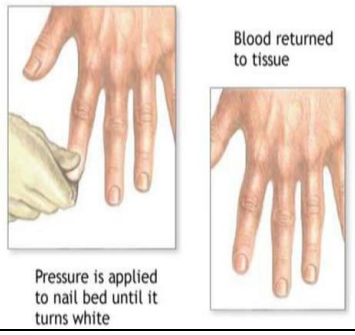
PROCEDURE GUIDE

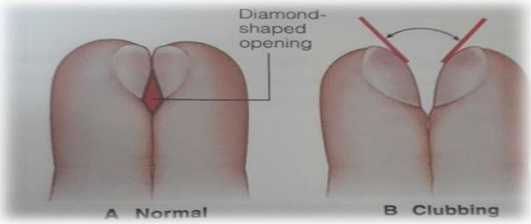
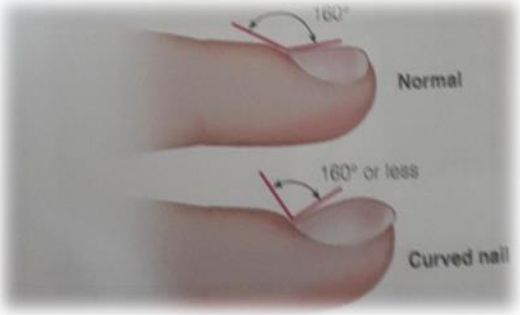
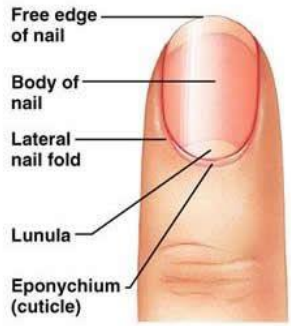
INSPECTION OF THE SKIN	
Procedure and Rationales	**Normal Findings**
1. Position the patient. ▪ **The patient should be in a sitting position with all clothing removed except the examination gown.**	
2. Instruct the patient. ▪ **Explain that you will be looking carefully at the patient's skin.**	
3. Observe for cleanliness, perspiration, or sheen on the skin and use the sense of smell to determine body odor.	• **Some perspiration is normal and results in a sheen on the skin in healthy individuals.** • **Body odor is produced when bacterial waste products mix with perspiration on the skin surface.** • **During heavy physical activity, body odor increases. Amounts of urea and ammonia are excreted in perspiration.**
4. Observe the patient's skin tone. ▪ **Evaluate any widespread color changes such as cyanosis, pallor, erythema or jaundice. Amount of melanin and carotene pigments, the oxygen content of the blood, and the level of exposure to sun influence skin color**	• **No cyanosis, pallor, erythema or jaundice.** • **Dark skin contains large amounts of melanin. While fair skin has small amounts.** • **The skin of most Asians contains large amount of carotene which causes a yellow cast.**
5. Inspect the skin for even pigmentation over the body. In most cases, increased or decreased pigmentation is caused by differences in the distribution of melanin throughout the body.	• **There are some normal variations. For example, the margins of the lips, areolae, nipples and external genitalia are more darkly pigmented. Freckles and certain nevi occur in**

	people of all skin colors in varying degree.
6. Inspect the skin for superficial arteries and veins.	• **A fine network of veins or a few dilated blood vessels visible just beneath the surface of the skin are normal findings in areas of the body where the skin is thin (e.g., the abdomen and eyelids).**
Palpation of the Skin	
Procedure and Rationales	**Normal Findings**
1. Determine the patient's skin temperature. ▪ **Use the dorsal surface of your fingers, which is most sensitive to temperature. Palpate the forehead or face first. Continue to palpate inferiorly, including the hands and feet, comparing the temperature on the right and left side of the body.** ▪ **Local skin temperature is controlled by the amount and rate of blood circulating through a body region.**	• **Normal temperature range from mildly cool to slightly warm.** • **The skin on both sides of the body is warm when tissue is perfused. Sometimes the hands and feet are cooler than the rest of the body but the temperature is normally similar on both sides.**
2. Assess the amount of moisture on the skin surface. ▪ **Inspect and palpate the face, skin folds, axillae, palms and soles of the feet, where perspiration is most easily detected.**	• **A fine sheen of perspiration or oil is not an abnormal finding nor is moderately dry skin, especially in cold or dry climates.**
3. Palpate the skin for texture. **Use the palmar surface of fingers and finger pads when palpating for texture.**	• **Normal skin feels smooth, firm and even.**
4. Palpate the skin to determine its thickness.	• **The outer layer of the skin is thin and firm over most parts of the body except the palms, soles of the feet, elbows and knees, where it is thicker. Normally, the skin over the eyelids and lips is thinner.**
5. Palpate the skin for elasticity. ▪ **Elasticity is a combination of turgor (resiliency, or the skin's ability to return to its normal position and shape) and mobility (the skin's ability to be lifted).**	• **Healthy skin is mobile and returns rapidly to its previous shape and position.** • **No edema noted.**

▪ **Use the forefinger and thumb, grasp a fold of skin beneath the clavicle or on the medial aspect of the wrist.** ▪ **Notice the reaction of the skin both as you grasp and as you release.**  ▪ **Finally, palpate the feet, ankles and sacrum. Edema is present if your palpation leaves a dent in the skin.** ▪ **Grade any edema on a four-point scale:** **1+ Mild pitting:** slight indentation: no perceptible swelling of the leg **2+ Moderate pitting:** indentation subsides rapidly **3+ Deep pitting;** indentation remains for a short time; legs look swollen. **4+ Very deep pitting;** indentation lasts a long time; leg is very swollen	
6. Inspect and palpate the skin for lesions. ▪ **Carefully inspect the patient's body including skinfolds and crevices, using a good source of light.** ▪ **In the obese patient this requires lifting the breasts and carefully examining the skin under folds in the abdomen, back and perineal area.** ▪ **When lesions are observed, palpate lesions between the thumb and index finger. Measure all lesion dimensions (including height, if possible) with a small, clear, flexible ruler.**	• **Healthy skin is typically smooth and free of lesions; however, some lesions, such as freckles, insect bites, healed scars, and certain birthmarks are expected findings.**

▪ **Document lesion size in centimeters. If necessary, use a magnifying glass or a penlight for closer inspection.** ▪ **Assess any drainage for color, odor, consistency, amount, and location. If indicated, obtain a specimen of the drainage for culture and sensitivity.**	
7. Palpate the skin for sensitivity. ▪ **Palpate the skin in various regions of the body and ask the patient to describe the sensations.** ▪ **Give special attention to any pain or discomfort that the patient reports, especially when palpating skin lesions.** ▪ **Ask the patient to describe the sensation as closely as possible, and document the findings.** **ALERT!** Localized hot, red, swollen painful areas indicate the presence of inflammation and possible infection. These areas should not be palpated, because the slightest disturbance may spread the infection deeper into skin layers.	• **The patient should not report any discomfort from your touch.**
Inspection of the Scalp and Hair	
Procedure and Rationales	**Normal Findings**
1. Observe for cleanliness. ▪ **Ask the patient to remove any hairpins, hair ties, barrettes, wigs, or hairpieces and to undo braids. If the patient is unwilling to do this, examine any strands of hair that are loose or undone.** ▪ **Part and divide the hair at 1-in. intervals and observe.**	• **A small amount of dandruff (dead, scaly flakes of epidermal cells) may be present.**
2. Observe the patient's hair color.	• **Hair color varies according to the level of melanin production. Graying is influenced by genetics and may begin as early as the late teens in some patients.**
3. Assess the texture of the hair. **Roll a few strands of hair between your thumb and forefinger.**	• **Hair may be thick or fine and may appear straight, wavy, or curly.**

Hold a few strands of hair taut with one hand while you slide the thumb and forefinger of your other hand along the length of the strand.	
4. Observe the amount of distribution of the hair throughout the scalp. ▪ Remember to assess the amount, texture and distribution of body hair. Some practitioners prefer to perform this assessment with the regions of the body.	• The amount of hair varies with age, gender, and overall health. Healthy hair is evenly distributed throughout the scalp.
5. Inspect the scalp for lesions.	• The healthy scalp is free from lesions.
Assessment of the Nails	
Procedure and Rationales	**Normal Findings**
1. Assess for hygiene. Confirm that the nails are clean and well groomed.	
2. Inspect the nails for an even, pink undertone.	• Color returns to healthy nails instantly upon release.
3. Assess capillary refill. ▪ Depress the nail edge briefly to blanch, and then release. ▪ This test is to monitor dehydration and blood supply.  	• Color returns to healthy nails instantly upon release.
4. Inspect and palpate the nails for shape and contour. ▪ Perform the Schamroth technique to assess clubbing. ▪ Ask the patient to bring the dorsal aspect of corresponding fingers together, creating a mirror image. ▪ Look at the distal phalanx and observe the diamond-shaped opening created by nails. When clubbing is present, the diamond is not formed and the distance increases at the fingertip.	• The nails normally form a slight convex curve or lie flat on the nailbed. When viewed laterally, the angle between the skin and the nail base should be approximately 160 degrees.

 **SCHAMROTH TECHNIQUE: A. HEALTHY NAIL. B. CLUBBING.**  **ANGLE OF FINGERNAIL.**	
5. Palpate the nails to determine their thickness, regularity and attachment to the nailbed. 	• **Healthy nails are smooth, strong, and regular and are firmly attached to the nailbed with only a slight degree of mobility.**
6. Inspect and palpate the cuticles.	• **Cuticles are smooth and flat in healthy nails.**

KING SAUD UNIVERSITY
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MEDICAL SURGICAL DEPARTMENT

NUR 221 HEALTH ASSESSMENT (PRACTICAL)
PERFORMANCE CHECKLIST
SKIN, HAIR AND NAIL ASSESSMENT

STUDENT'S NAME: _____ RATING: _____
STUDENT'S NUMBER: _____ DATE PERFORMED: _____

THE STUDENT NURSE SHOULD BE ABLE TO:

Performance Criteria	COMPETENCY LEVEL			
	DONE CORRECTLY	DONE WITH ASSISTANCE	NOT DONE	COMMENTS
Preparation				
Prepare the necessary equipment.				
Review interview note.				
Explain procedure.				
Conduct general survey.				
Position and drape patient correctly.				
Expose body part to be examined and drape patient appropriately.				
Ensure adequate light.				
Ensure patient privacy				
Wash hands.				
Follow Inspection and Palpation				
INSPECTION OF THE SKIN				
1. Position the patient. ▪ **Patient should be in a sitting position with all clothing removed except the examination gown.**				
2. Instruct the patient. ▪ **Explain that you will be looking carefully at the patient's skin.**				
3. Observe for cleanliness, perspiration, or sheen on the skin and use the sense of smell to				

determine body odor.				
4. Observe the patient's skin tone. ▪ Evaluate any widespread color changes such as cyanosis, pallor, erythema or jaundice. Amount of melanin and carotene pigments, the oxygen content of the blood, and the level of exposure to sun influence skin color				
5. Inspect the skin for even pigmentation over the body.				
6. Inspect the skin for superficial arteries and veins.				
PALPATION OF THE SKIN				
1. Determine the patient's skin temperature.				
2. Assess the amount of moisture on the skin surface				
3. Palpate the skin for texture.				
4. Palpate the skin to determine its thickness.				
5. Palpate the skin for elasticity.				
6. Inspect and palpate the skin for lesions.				
7. When lesions are observed: ▪ Palpate lesions between the thumb and index finger.				
▪ Measure all lesion dimensions (including height, if possible) with a small, clear, flexible ruler.				
▪ Document lesion size in centimeters.				
▪ Assess any drainage for: - Color - Odor - Consistency - Amount - Location - Obtain a specimen of the drainage for culture and sensitivity, if indicated.				
8. Palpate the skin for sensitivity.				

Inspection of the Scalp and Hair				
1. Observe for cleanliness.				
2. Observe the patient's hair color.				
3. Assess the texture of the hair.				
4. Observe the amount of distribution of the hair throughout the scalp. ▪ Assess the amount, texture and distribution of body hair.				
5. Inspect the scalp for lesions.				
Assessment of the Nails				
1. Assess for hygiene.				
2. Inspect the nails for an even, pink undertone.				
3. Assess capillary refill.				
4. Inspect and palpate the nails for shape and contour.				
▪ Perform the Schamroth technique to assess clubbing.				
5. Palpate the nails to determine their thickness, regularity and attachment to the nailbed.				
6. Inspect and palpate the cuticles.				
Document findings.				

Evaluated by : _____
Date of Evaluation : _____

References:

- **D' Amico, D. Health & Physical Assessment in Nursing, 3rd Ed. (2016). Pearson, Cloth. ISBN-10_0133876403. ISBN-13:9780133876406**
- **Jarvis C. Physical Examination and Health Assessment. St. Louis 7th Ed. (2015). Missouri, Saunders Elsevier.**