#Jenny

Finally I get this ebook, thanks for all these I can get now!

#Rio

Cool! I'am really happy

#Markus Jensen

I did not think that this would work, my best friend showed me this website, and it does! I get my most wanted eBook

#Hun Tsu

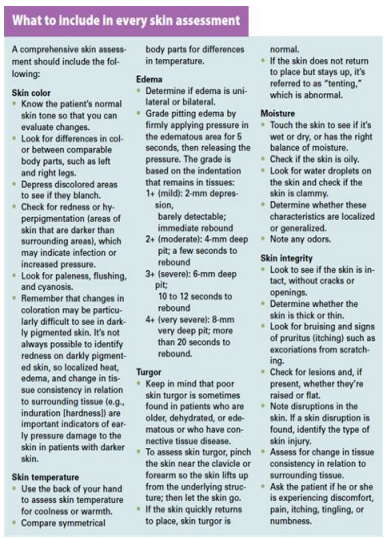
wtf this great ebook for free?!

#Che Salsa

My friends are so mad that they do not know how I have all the high quality ebook which they do not!

#Diego Butler

so many fake sites. this is the first one which worked! Many thanks



What to include in every skin assessment

A comprehensive skin assessment should include the following:

Skin color
- Know the patient's normal skin tone so that you can evaluate changes.
- Look for differences in color between comparable body parts, such as left and right legs.
- Depress discolored areas to see if they blanch.
- Check for redness or hyperpigmentation (areas of skin that are darker than surrounding areas), which may indicate infection or increased pressure.
- Look for paleness, flushing, and cyanosis.
- Remember that changes in coloration may be particularly difficult to see in darkly pigmented skin. It's not always possible to identify redness on darkly pigmented skin, so localized heat, edema, and change in tissue consistency in relation to surrounding tissue (e.g., induration [hardness]) are important indicators of early pressure damage to the skin in patients with darker skin.

Skin temperature
- Use the back of your hand to assess skin temperature for coolness or warmth.
- Compare symmetrical body parts for differences in temperature.

Edema
- Determine if edema is unilateral or bilateral.
- Grade pitting edema by firmly applying pressure in the edematous area for 5 seconds, then releasing the pressure. The grade is based on the indentation that remains in tissues:
  1+ (mild): 2-mm depression, barely detectable; immediate rebound
  2+ (moderate): 4-mm deep pit; a few seconds to rebound
  3+ (severe): 6-mm deep pit; 10 to 12 seconds to rebound
  4+ (very severe): 8-mm very deep pit; more than 20 seconds to rebound.

Turgor
- Keep in mind that poor skin turgor is sometimes found in patients who are older, dehydrated, or edematous or who have connective tissue disease.
- To assess skin turgor, pinch the skin near the clavicle or forearm so the skin lifts up from the underlying structure; then let the skin go.
- If the skin quickly returns to place, skin turgor is normal.
- If the skin does not return to place but stays up, it's referred to as "tenting," which is abnormal.

Moisture
- Touch the skin to see if it's wet or dry, or has the right balance of moisture.
- Check if the skin is oily.
- Look for water droplets on the skin and check if the skin is clammy.
- Determine whether these characteristics are localized or generalized.
- Note any odors.

Skin integrity
- Look to see if the skin is intact, without cracks or openings.
- Determine whether the skin is thick or thin.
- Look for bruising and signs of pruritus (itching) such as excoriations from scratching.
- Check for lesions and, if present, whether they're raised or flat.
- Note disruptions in the skin. If a skin disruption is found, identify the type of skin injury.
- Assess for change in tissue consistency in relation to surrounding tissue.
- Ask the patient if he or she is experiencing discomfort, pain, itching, tingling, or numbness.