Resource Sheet – Skin Assessment and Documentation of Patients with Dark Skin Tone (DST)

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What does the literature say about skin assessment and documentation of patients with Dark Skin Tone?

- Patients with DST are more at risk for pressure injuries (PI).
- Black race or Hispanic ethnicity are independent risk factors for PI. Of U.S. patients with a hospital discharge diagnosis of PI, 32% identified as African American.
- The mortality rate for African American patients with a PI is 9.1% compared to 1.8% for Caucasian patients.
- Healthcare providers recognize PI on DST at later stages which causes delayed interventions and treatments, underdiagnosed comorbidities, and increased hospital length of stay and mortality.
- Current guidelines recommend regular PI prevention and treatment education include assessment techniques and documentation of PI characteristics and terms specific to darkly pigmented skin.
- Providers have difficulty identifying pressure-related changes on visual inspection alone, as the naked eye cannot discern blanching nor discern a Stage 1 versus DTI in patients with DST. Tactile characteristics are more likely to assist in DST assessments. Pain is a key symptom in PI assessment, especially in DST.
- Skin tone is more predictive of skin damage than ethnicity or race. Objective skin tone or pigment scales, such as the Munsell Color Chart, have shown increasing sensitivity of DST PI risk assessment for clinical practice and research.

Who does this apply to?

- All patients (pediatrics and adults) with dark skin tones
- Patients with skin types rich in melanin pigments including, but not limited to, Black, Indigenous, and People of Color (BIPOC)

What are the potential benefits & harms?

- Benefits
    - Consistent skin assessment of DST
    - Earlier identification of pressure injuries
    - Assists in identifying the need for interventions
    - Improved patient outcomes
- Harms
    - No harms identified

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What does this mean for nurses?

Skin assessments of patients with DST should include the following, specifically for areas at risk for tissue injury such as bony prominences and medical device locations:

1. **Inspect** for erythema, discoloration, or changes in texture or color from surrounding skin. Assess for skin that appears taut or shiny. Color changes on DST may appear more blue, purple, maroon, gray, brown, or black in color with a shiny or taut appearance.
    a. Moisten the skin with water to better visualize color changes
2. **Palpate** for areas of tissue inconsistencies such as induration often described as hard, firm, or boggy often caused by underlying sub-epidermal moisture/edema, infection, or inflammation.
    a. Assess blanching response by pressing the skin with a finger close to a capillary bed to assess the color return after releasing pressure. It is normal and common for dark skin tones not to have a visible blanch response.
    b. Use the back of your clean hand without gloves to best feel for temperature changes (cooler or warmer) compared to surrounding skin.
3. **Ask the patient about localized pain or sensation changes.**
    a. As you palpate over areas at risk for pressure injury, ask the patient if they have pain, numbness, tingling, or loss of sensation.
4. **Document** assessment findings that do not meet "Within Defined Limits" criteria either as:
    a. Localized skin alterations on the assessment flowsheet under "tissue integrity" expand the "skin alterations"
    b. An identified wound or pressure injury on the Wound LDA flowsheet

What additional resources are available?

- Video reference for skin assessment and documentation on patients with DST https://www.youtube.com/watch?v=vXZmqWXXwJw
- NPIAP Staging for Darkly Pigmented Skin (attached NPIAP PDF)
- Articles:

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