Assessment of peristomal skin using the PLACED tool and terminology

Wendy Osborne (MSc; QN)

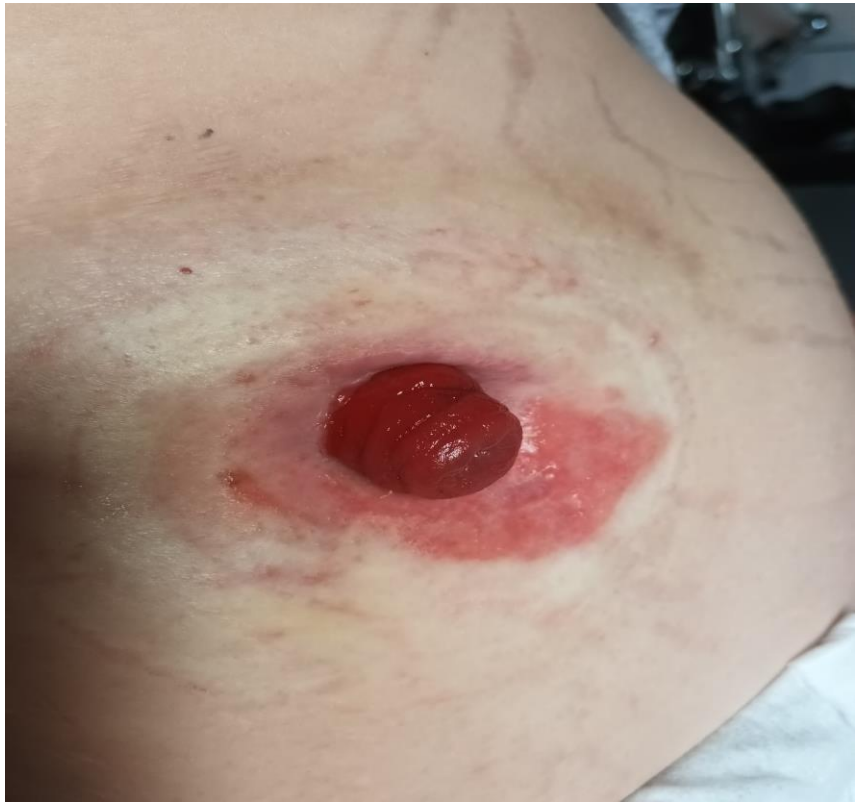
CNS Stoma Care

Clinical Governance Lead; Coloplast

Governance Officer ASCN UK

Association of Stoma Care Nurses UK

"Ostomy patients are dependent on the integrity of their peristomal skin to maintain a normal lifestyle".



Nybaek H & Jemec G (2010)

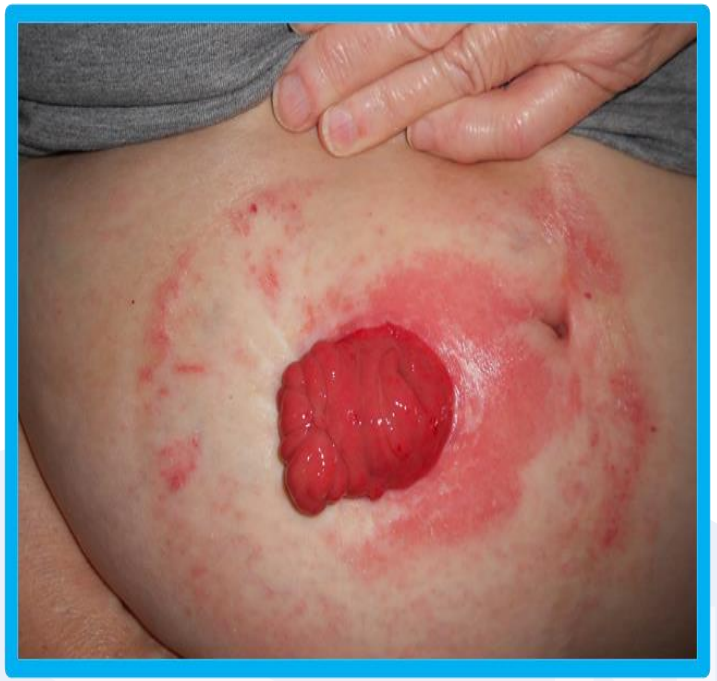
However; the incidence of Peristomal Skin Complications (PSC) is significantly high

Assessment and review of peristomal skin health is among the most common reasons for SCN review

45%	Herlufsen et al 2006	Danish study 202 ostomates
36.7%	Taneja et al 2019	128 ostomates – PSC during first 90 days following ostomy surgery
73%	Voegeli et al 2020	International survey – 4235 ostomates

A visual description is the first part of the specialist assessment however….

As experienced Nurse Specialists we often make an instinctive peristomal assessment. We focus on the cause and treatment omitting documenting the visual description of the peristomal skin condition



Use of an acronym to guide your documentation

- This is not a diagnostic tool it is an aide memoire
- To promote quality: by enabling detail within your documentation
- To capture and describe the condition of the peristomal skin as seen on visual assessment

P.L.A.C.E.D

Patient Sensation of skin damage by the patient

Look How many lesions e.g. flat, raised or ulcerated

Area Position & size of the peristomal skin lesion

Colour Describe the colour of the peristomal skin lesion

Extent Describe depth of erosion/skin damage

Digit What does it feel like to touch

P.L.A.C.E.D	Peristomal Skin Tool prompts for structure and quality
Patient	**Describe skin lesion sensation by the patient** • None; itchy; painful; burning; tingly
Look	**Describe visual assessment of the peristomal skin** **Total number of lesions** – sporadic; one area (describe each one) • **Flat** – rash; dermatitis (*skin inflammation*) • **Raised** – rash; over-granulation; dermatitis; plaque; water logged (*macerated and oedematous*); fluid filled (*blister*); papules • **Depressed** – ***ulcer** • Skin tear; prominent veins; defined or ill-defined edges
Area	**Describe position and size of the peristomal skin lesion** (use clock face to describe) • **Position** – circumferential; mucocutaneous junction; peristomal (*under adhesive*), parastomal (*periphery of appliance*) • **Measure size** – top to bottom and left to right (mm)
Colour	**Describe the colour of the peristomal skin lesion** • Normal (compared to abdomen); red; shiny; hyperpigmentation; grey; bruising; blue/purple; translucent; white; yellow/green; black
Extent	**Describe depth of the skin lesion** • Intact; erythema (blanching or non-blanching) • Raised – e.g. over-granulation, papules • Epidermal erosion *(skin lesion no bleeding)*; dermal erosion (*bleeding skin lesion*); subcutaneous layer visible; ***ulcer**
Digit	**Describe the physical assessment of skin lesion** • Dry; wet; heat; hard; pitting; turgid

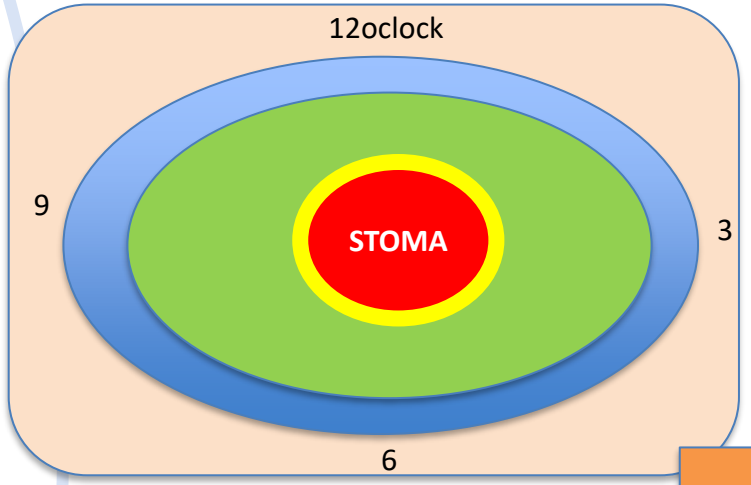
***ulcer – risk of ulceration even when skin intact**

P.L.A.C.E.D	Peristomal Skin Tool prompts for structure and quality
Patient	**Describe skin lesion sensation by the patient** • None; itchy; painful; burning; tingly
Look	**Describe visual assessment of the peristomal skin** **Total number of lesions** – sporadic; one area (describe and number each lesion) • **Flat** – rash; dermatitis (*skin inflammation*) • **Raised** – rash; over-granulation; dermatitis; plaque; water logged (*macerated and oedematous*); fluid filled (*blister*); papules • **Depressed** – ***ulcer** • **Skin tear**; prominent veins; defined or ill-defined edges
Area	**Describe position and size of the peristomal skin lesion** (use clock face to describe) • **Position** – circumferential; mucocutaneous junction; peristomal (*under adhesive*), parastomal (*periphery of appliance*) • **Measure size** – top to bottom and left to right (mm)
Colour	**Describe the colour of the peristomal skin lesion** • Normal (compared to abdomen); red; shiny; hyperpigmentation; grey; bruising; blue/purple; translucent; white; yellow/green; black
Extent	**Describe depth of the skin lesion** • Intact; erythema (blanching or non-blanching) • Raised – e.g. over-granulation, papules • Epidermal excoriation *(skin lesion no bleeding)*; dermal excoriation (*bleeding skin lesion*); subcutaneous layer visible; ***ulcer**
Digit	**Describe the physical assessment of skin lesion** • Dry; wet; heat; hard; pitting; turgid

Date:
Patient Name :
NHS No:
Nurse Name & Signature
Photo taken Y/N

PERISTOMAL SKIN TOOL
P.L.A.C.E.D.

Association of Stoma Care Nurses UK



Patient Sensation of skin damage by the patient

Look How many lesions e.g. flat, raised or ulcerated

Area Position & size of the peristomal skin lesion

Colour Describe the colour of the peristomal skin lesion

Extent Describe depth of erosion/skin damage

Digit What does it feel like to touch

Label all individual skin lesions on diagram

Area	P	L	A	C	E	D	Other comments
Mucocutaneous Junction							
Peristomal – (under adhesive)							
Parastomal – (outside adhesive)							
Anywhere else (on the body)							

Blister
Water filled pocket of fluid between the epidermal and dermal skin layer.

Dermatitis
(Inflamed skin) the skin's reaction to an irritant. The degree of the pathological response determines whether it is a contact or allergic dermatitis. Irritant contact dermatitis typically presents as a well defined erythema, which can be oedematous, itch and occasionally blisters. Necrosis can occur in severe cases and a secondary infection may be present.

Contact Irritants include; faeces/urine/product ingredients/chemicals.

Dermis
The layer of skin beneath the epidermis which bleeds if damaged.

Epidermis
Outer layer of the skin, no bleeding if damaged.

Erythema
Skin appearance is red in colour due to increased blood flow causing vaso-dilation within stratum corneum of epidermis which causes heat - the epidermis is intact:

- Blanching erythema *(redness)* - When light pressure applied for 10 seconds and on removal the skin tone returns to normal.
- Non blanching erythema - When light pressure applied for 10 seconds and on removal the skin tone does not immediately return to normal as no capillary refill.

Excoriation (peristomal)
Ill defined loss of the peristomal epidermis due to persistent irritation, typically from urine/faeces with a bright red appearance and bleeding if it includes the dermis.

Hyperpigmentation
Darkening of the skin due to excess melanin deposits in the skin.

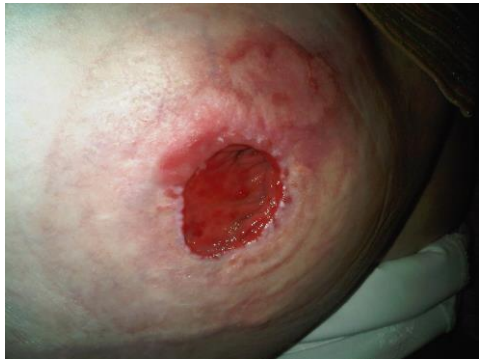
Hypodermis (subcutaneous)
Layer below the dermis which consists largely of fat.

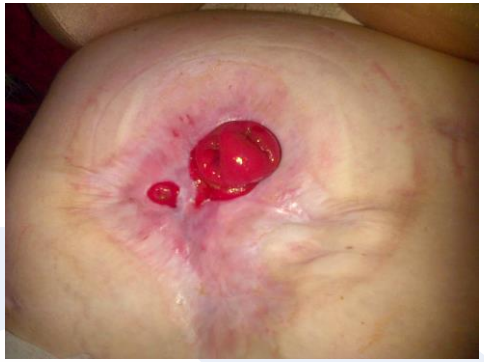
Proposal for classifying Peristomal Ulceration

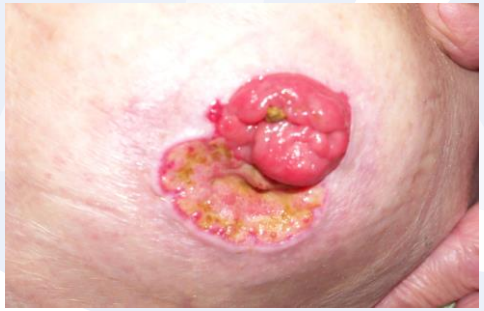
Ulceration = loss of the layers of the epidermis and dermis and can extend into the underlying tissue.

Should peristomal ulceration be defined as;

- ***Stage 1*** – ***At risk of ulceration developing***
  Appearance – non blanching erythema
- ***Stage 2*** - ***Peristomal Ulceration***
  Appearance - epidermis broken red, wet painful
- ***Stage 3*** - ***Peristomal Ulceration***
  Appearance - damage to dermal layer and into subcutaneous layer; pain not constant



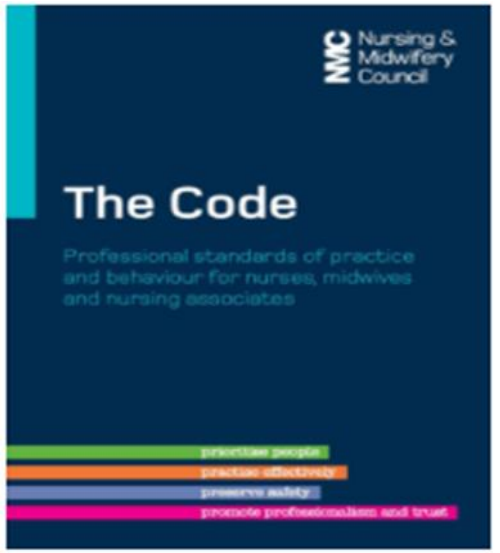




The key takeaway is - describe **what you see**

Describe and document what you see BEFORE you identify cause and treatment

- **Why is this important** ?
  - ✓ Capture the detailed appearance of skin abnormality and variations in skin health within the peristomal area; adding context and value to your Skin scoring tool
  - ✓ Provides evidence and rationale for your clinical judgement, critical thinking & decision making based on your assessment
  - ✓ Enables clarity in the effectiveness to treatment
  - ✓ Promote effective communication through the quality of your documentation
  - ✓ Encourage consistency of terminology between us as specialists and promote accuracy in the interpretation of our observations
  - ✓ Promote standardisation of how we as a professional body structure and document our assessments



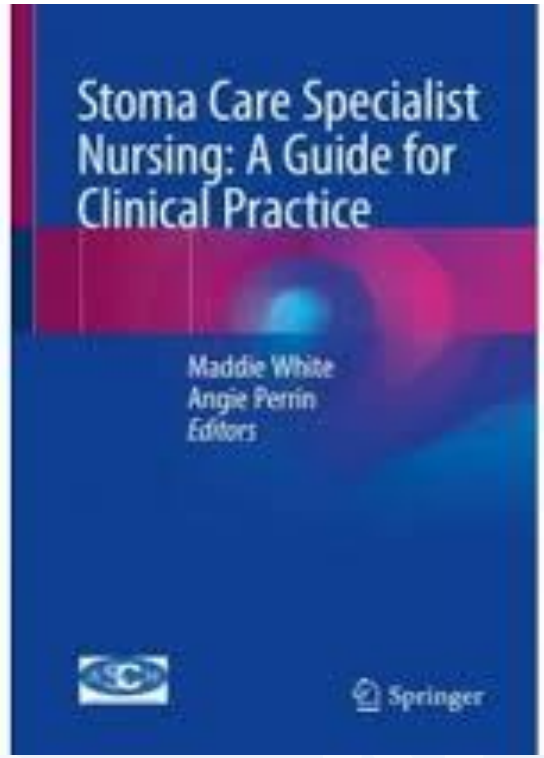
Royal College of Nursing
The voice of nursing

Thank you to my colleagues

- The ASCN UK – peristomal skin project group
  - Maddie White, Ben McDermott, Anna Boyles,
  - Moira Evans, Rosie Callaghan, Callum Lyons

- The ASCN UK committee & membership – for feedback on the P.L.A.C.E.D tool

- To our patients who have provided consent for sharing of these photographs



REFERENCES for peristomal skin assessment

- Burch J; Marsden J; Boyles A; Martin N; Voegelo D; McDermott B; Maltby E (2021) Keep it simple: peristomal skin health, quality of life and wellbeing. Best practice consensus document on skin health. BJN 30 (6, Supp 1) 1-24
- Colwell JC, Bain KA, Hansen AS, Droste W, Vendelbo G, James-Reid S.(2019) International Consensus Results: Development of Practice Guidelines for Assessment of Peristomal Body and Stoma Profiles, Patient Engagement, and Patient Follow-up. J Wound Ostomy Continence Nurs. 46(6):497-504.
- Heerschap C, & Butt B. (2021) Algorithmic approaches to ostomy management: an integrative review. Nurs Open; Nov; 8(6):2912-2921.
- Malik T; Lee M; Harikrishnan A (2018) The incidence of stoma related morbidity – a systematice review of randomised controlled trials. Ann R Coll Surg Engl. Sept;100 (7) 501-508 DOI: 10.1308/rcsann.2018.0126
- Nybaek H & Jemec G (2010) Skin Problems in stoma patients; J Eur Acad Dermatol Verereol Mar;24 (3); 249-57 PMID: 20465716
- DOI: 10.1111/j.1468-3083.2010.03566.x
- Ratliff C, Goldberg M, Jaszarowsk K, McNichol L, Pittman J, Gray M. (2021) Peristomal Skin Health: A WOCN Society Consensus Conference: J Wound Ostomy Continence Nurs.;48(3): 219-231. https://doi.org/10.12968/gasn.2020.18.Sup4.S31
- Voegeli D; Kalsmark T; Eddes E H; Hansen H; Zeeberg R; Hakan-Bloch J ; Hedegaard C (2020) Factors influencing the incidence of peristomal skin complications; evidence from a multinational survey on living with a stoma. Gin vol.18 sup4