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

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