



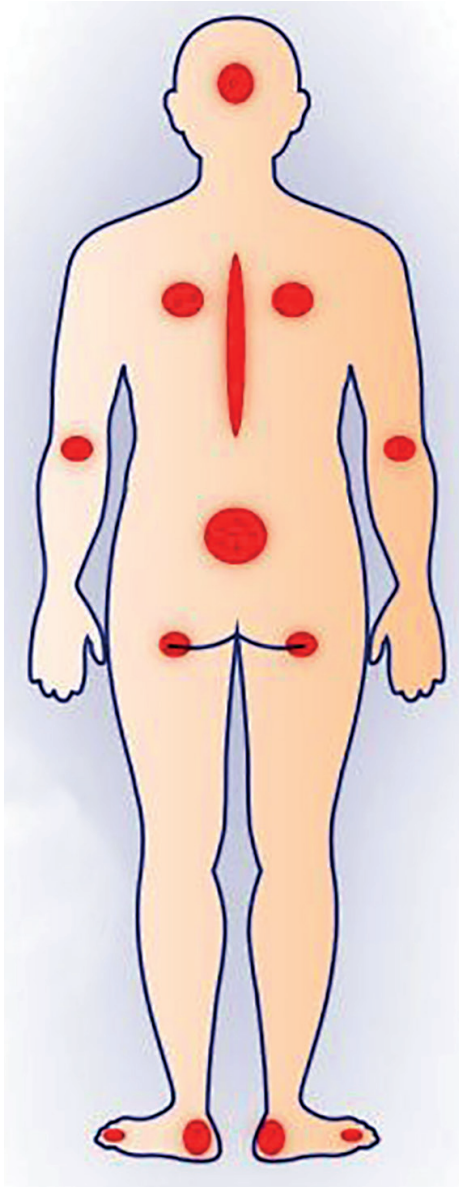
Patient Information (or affix ID label)

Patient Name
Hospital Number
Date Time

RN Skin Inspection Checklist

Check areas and document skin at least twice daily

Please circle affected area of patients body. **Highlighted areas must be thoroughly checked**



Are there any signs of pressure damage?

Redness / erythema
Yes No

Non-blanching persistent erythema / redness (NBE)
Yes No
Apply light finger pressure to area of discolouration for 10 seconds

Pain / soreness
Yes No

Warmer / cooler over bony prominence
Yes No

Spongy feeling
Yes No

Hardened
Yes No

Discolouration*
Yes No
In those with darkly pigmented skin redness is not always obvious, look for any colour changes in comparison to surrounding areas, other indicators will be warmth/cooler, hardening/oedema and spongy areas.

Broken skin
Yes No
You must complete a wound assessment for any open wounds

Name, signature and Designation:

Date and Time:

Action taken:

Check all areas and beneath all devices

BEST SHOT

Buttocks

Elbows / Ears

Sacral area

Trochanter (hips)

Spine / shoulders

Heels

Occipital / back of head

Toes

Devices

O2

Catheters

Collars

Splints

Others:

Non present:

Please tick appropriate box

Green: No sign of pressure damage - continue to inspect skin at least daily or re-assess if clinical change and document on pressure area care plan

Non Blanching Redness (NBE): Early signs of pressure damage, update pressure area care plan move patient off red area and float heels, observe every 2 hours until redness resolves

NBE with one or more red ticks: Update pressure area care immediately, communicate findings at huddles, consider changing mattress and referral to TVN. Use aSKING care plan to check care and identity changes

This guide is to direct your twice daily skin inspections and allows body map completion at the bedside - it does not replace the care plan and more detailed information should be recorded on the plan including position changes, detailed findings and action taken



Patient Information (or affix ID label)

Patient Name

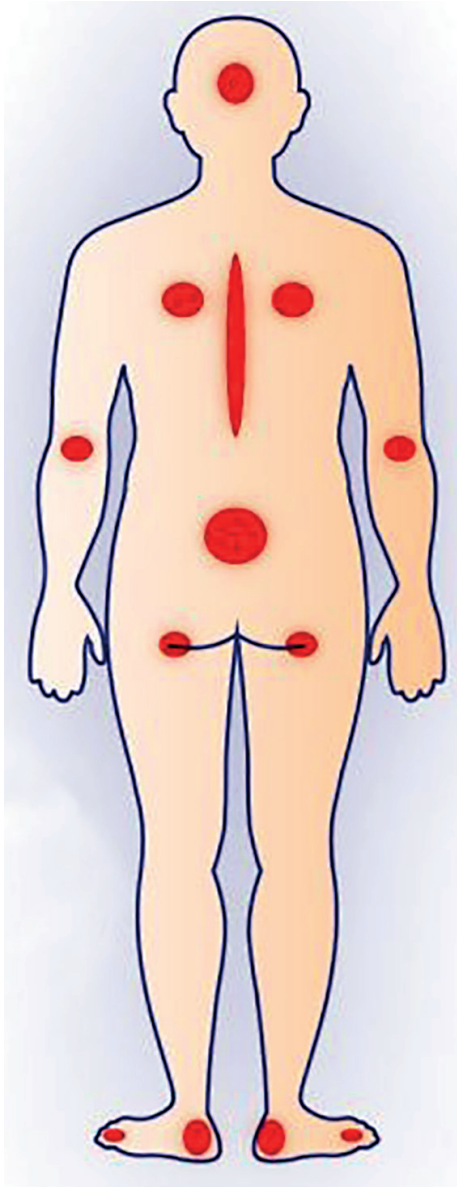
Hospital Number

Date Time

RN Skin Inspection Checklist

Check areas and document skin at least twice daily

Please circle affected area of patients body. **Highlighted areas must be thoroughly checked**



Are there any signs of pressure damage?

Redness / erythema
Yes No

Non-blanching persistent erythema / redness (NBE)
Yes No
Apply light finger pressure to area of discolouration for 10 seconds

Pain / soreness
Yes No

Warmer / cooler over bony prominence
Yes No

Spongy feeling
Yes No

Hardened
Yes No

Discolouration*
Yes No
In those with darkly pigmented skin redness is not always obvious, look for any colour changes in comparison to surrounding areas, other indicators will be warmth/cooler, hardening/oedema and spongy areas.

Broken skin
Yes No
You must complete a wound assessment for any open wounds

Name, signature and Designation:

Date and Time:

Action taken:

Check all areas and beneath all devices

BEST SHOT

Buttocks

Elbows / Ears

Sacral area

Trochanter (hips)

Spine / shoulders

Heels

Occipital / back of head

Toes

Devices

O2

Catheters

Collars

Splints

Others:

Non present:

Please tick appropriate box

Green: No sign of pressure damage - continue to inspect skin at least daily or re-assess if clinical change and document on pressure area care plan

Non Blanching Redness (NBE): Early signs of pressure damage, update pressure area care plan move patient off red area and float heels, observe every 2 hours until redness resolves

NBE with one or more red ticks: Update pressure area care immediately, communicate findings at huddles, consider changing mattress and referral to TVN. Use aSKING care plan to check care and identity changes

This guide is to direct your twice daily skin inspections and allows body map completion at the bedside - it does not replace the care plan and more detailed information should be recorded on the plan including position changes, detailed findings and action taken