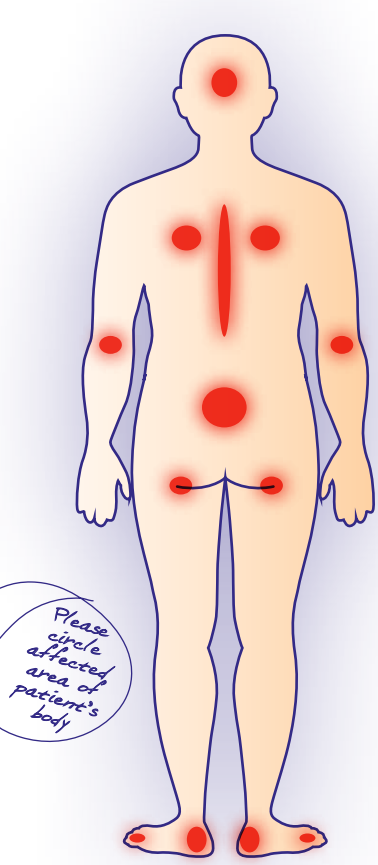
Skin inspection guide

Check most vulnerable areas and document pressure areas at least once a day

Great SKIN

Patient name: _____ Date: / /



Are there any signs of pressure damage?

Redness/erythema ☐ Yes ☐ No

Non-blanching persistent erythema ☐ Yes ☐ No

Use your skin fob or apply light finger pressure to the area of discolouration for 10 seconds

Pain/soreness ☐ Yes ☐ No

Warmer/cooler over bony prominence ☐ Yes ☐ No

Boggy feeling ☐ Yes ☐ No

Hardened ☐ Yes ☐ No

Discolouration* ☐ Yes ☐ No

In those with darkly pigmented skin, discolouration may not be visible and other indicators will be warmer/colder, hardening/oedema (boggy skin).

Broken skin ☐ Yes ☐ No

Name

Action

Please continue over/leaf if necessary

GREEN

No signs of pressure damage: Continue to inspect skin daily and encourage regular repositioning.

AMBER

Early signs of pressure damage: Monitor patient closely and start patient on pressure ulcer prevention plan / SSKIN bundle. Carers must inform qualified nurse/ community nurse.

RED

Pressure damage: This must be documented immediately on a wound assessment chart and treatment started to prevent further damage, including pressure ulcer management plan / SSKIN bundle. Inform tissue viability nurse specialist and GP.

For more information visit
www.stopthepressure.com

NHS
Midlands and East