FORM A. Example Skin Inspection Form

NAME:														
Date & Time														
Head														
Left Ear														
Right Ear														
Left Elbow														
Right Elbow														
Sacrum														
Left Buttock														
Right Buttock														
Left Hip														
Right Hip														
Left Knee														
Right Knee														
Left Heel														
Right Heel														
Left Ankle														
Right Ankle														
Other Please state														
Sign/initial														

Normal Appearance 0
Change in Appearance 1

If 1 is written there must be an entry in the care records stating what the change is, the intervention required and when the intervention has been completed.

FORM B. Example Body Map Guidance

A Body Map should be used to document and illustrate visible signs of harm and physical injuries.

Clearly mark on the body map:

- Pressure ulcers
- Red areas
- Bruises
- Cuts, lacerations and wounds
- Scalds and burns
- Swellings.
- Insect Bites
- Existing scars, birth marks etc.

Provide details such as:

- Size, measure if possible or compare to a common object e.g. size of a 10p coin.
- Colour
- Grade of pressure ulcer – if known.

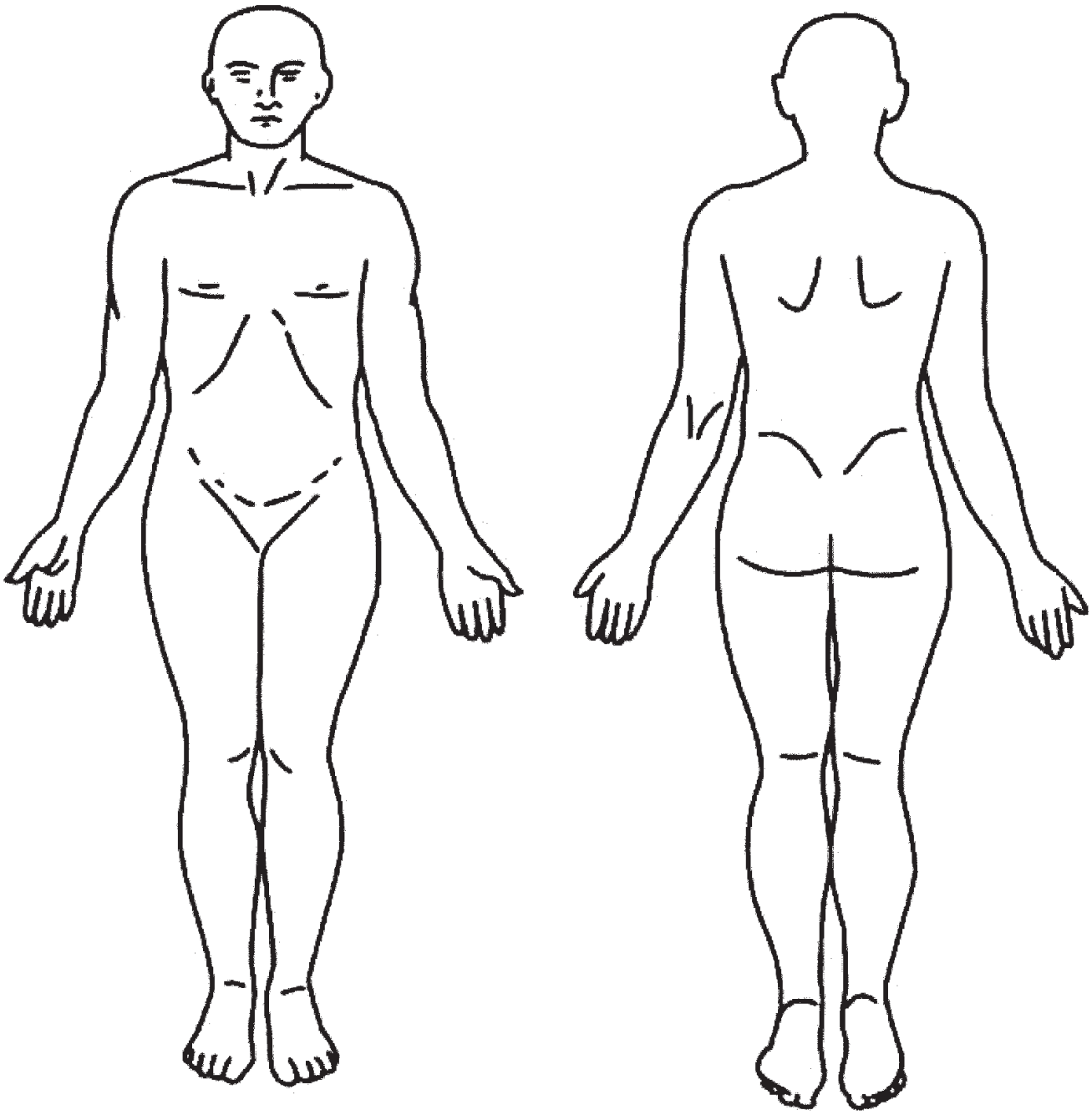
Always record:

- The date of the record
- The time the record was made and
- The name and designation of the person making the record.

Use the notes section to add any further comments.
As the wound or mark changes a new record should be made.
A copy of all body charts must be kept in the individuals records.
Always use a black pen

BODY MAP

Name:
Date:



Notes:

FORM C. Example Skin Assessment Tool - (Waterlow)

Undertake and document risk assessment within 6 hours of admission or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol.

More than one score/category can be used:
10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk'

Sex									
Male	1								
Female	2								
Age									
14 – 49	1								
50 – 64	2								
65 – 74	3								
75 – 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m^2)									
Average – BMI 20-24.9	0								
Above average – BMI 25-29.9	1								
Obese – BMI > 30	2								
Below average – BMI < 20	3								
Continence									
Complete/catheterised	0								
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type – Visual Risks Area									
Healthy	0								
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0								
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by severe pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4								
Chair bound (unable to leave chair without assistance)	5								
Nutritional Element									
Unplanned weight loss in past 3-6 months									
< 5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2								
BMI >20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient/ client acutely ill or no nutritional intake > 5 days	2								
Special Risks – Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8								

Single organ failure e.g. cardiac, renal, respiratory	5								
Peripheral vascular disease	5								
Anaemia = Hb < 8	2								
Smoking	1								
Special Risks – Neurological Deficit									
Diabetes/ MS/ CVA/ motor/ sensory/ paraplegia *Max 6*	4-6								
Special Risks – Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/ below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5								
Special Risks – Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4								
Total Score									
Date									
Initials									
Time									

Ensure plan of care is implemented / reviewed for all identified areas of concern.

(*Adapted form from Scotland NHS Quality Improvement Waterlow Pressure Area Risk Assessment Chart)*