Health Service:	Medical Rec No:			
Comprehensive Skin Assessment	Surname:			
	Forename: Anita			
	Gender: D.O.B:			

Complete initial skin assessment within 8 hours of presentation. Document any **impaired** skin characteristics using the tool below, carry out actions if required and sign as per the reverse side of this document. Reassess the skin daily and whenever there is a change in the patient's condition, and upon transfer/discharge.

A skin assessment should include an actual observation of the entire body surface, including all wounds*, inspection of hair, nails, skin folds and web spaces on hands and feet, systematically from head to toe.

*If patient has compression bandaging, or topical negative pressure therapy – leave intact, assess the skin at next dressing change.

Skin Characteristics	Description Please ✓ impaired skin characteristics		CODE	Identify the location using the code provided:
Temperature		Cooler than normal Warmer than normal/hot Hot/ very inflamed	C W H	Right
Moisture		Dry Moist to touch	D M	Left
<i>Turgor</i> ^ - gently lift skin on the back of patient's hand between your thumb and index finger		Normal (< 3 seconds) Impaired (if >3 seconds) Oedema Induration	I O In	
Integrity		Fragile Pressure injury Flake / scale Rash Wound Scarring Callus Cellulitis Known skin disorder - Specify type: Grade 3 PU	Fr PI FI Wd S Ca Ce	
<i>Colour</i> Taking into account the person's natural skin colour e.g. caucasian or darker skin tone		Note areas of; pallor, cyanosis, bruising, jaundice, blanching, persistent redness, mottled skin, bluish or purple tones. Describe appearance & location:		Left
Altered sensation (^as applicable)		Numbness / change Burning Itching Pain	N B It P	and (f) has
<i>Medical devices insitu</i> (circle or describe) Mark location on diagram.		e.g. Masks, ETT, NGT, tracheostomy, cervical collars, cannulae, IV, PEG tube, splints/anti- embolic devices / cast, SPC, IDC, drainage tubes, transfer equipment, other.		

^For infants and neonates please consider gestational age.

Other Actions Required		Initiate referral to (as required):				
 Implement skin protection strategies Initiate pressure redistribution support surface Undertake wound assessment if required Initiate patient and family/carer education Discuss the patient's skin integrity and skin protection strategies with the patient/carer 			 Wound Care Nurse/CNS/CNM/NP(Wound Mx) Stomal Therapy Nurse Medical Officer Allied health Other 			
Initial skin assessment completed:						
Date & Time	Comments			Signature and designation Print Name		
Re-Asse						
Date & Time	Skin intact Y/N	New issue, deterioration or action (describe)		Signature and designation Print Name		