Skin inspection guide

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

Patient name: ___________________________ Date: __/__/____

**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