SKIN IQ CUSTOMER EVALUATION FORM

ARJOHUNTLEIGH
GETINGE GROUP

EVALUATION SITE DETAILS

Evaluation site

Unit / Speciality

Clinician contact

Instructions for completing this form

- Please complete **all** sections
- Check appropriate boxes with a ✘ or ✔
- Add extra information / comments as necessary
- Hand back to your local company representative

Completed by

Date current evaluation started

DD / MM / YY

CLINICAL DETAILS

Age yrs Sex M F Weight kg Height m

Bariatric products

Shape

	✓
Apple Shape	
Pear Shape	
Proportional	

BMI

Body Mass Index = Weight (Kg) / Height (M^2)

Underweight	< 20
Healthy Weight	20 – 24.9
Overweight	25 – 29.9
Obese (Class 1)	30 – 34.9
Obese (Class 2)	35 – 40
Morbid Obesity	40+

	✓
Was this data estimated?	
or accurate?	

Reason for admission

Please give brief details

State product in use prior to this valuation

Duration of use

PRODUCT DETAILS

Type of bed frame in use

	✓
Manual bed frame	
Electronic bed frame	

Type of mattress in use

Foam mattress	
Mattress Replacement	
Mattress Overlay	
Low Air Loss mattress	
Non Powered Mattress Replacement	

Type of base mattress, if applicable:

RISK FACTORS

Risk tool if used

Risk score if applicable

Risk factors identified:

	✓		✓
Poor nutrition	☐	Altered sensation	☐
Peripheral vascular disease (PVD)	☐	Recent weight loss	☐
Incontinent of urine	☐	Sweating	☐
Incontinent of faeces	☐	Paralysis	☐
Surgery > 2 hours	☐	Previous healed ulcer	☐
Diabetic	☐	Other	☐

Level of Moisture Present:

Constantly moist	☐	Occasionally moist	☐
Very moist	☐	No impairment	☐

If other, please state

ASSESSMENT OF MOBILITY

	Yes ✓	No ✓
Can the patient move unaided e.g. sit up in bed, turn from side to side?	☐	☐
Does the patient have an assisted repositioning regime?	☐	☐

Repositioning Frequency:

	✓
Less than 2 hourly	☐
2 hourly	☐
3-4 hourly	☐
Other	☐

If other, please state

If the patient cannot be repositioned i.e. turned/sat up in bed, please specify reason

	Yes ✓	No ✓
Does the patient sit out of bed?	☐	☐

If yes, how long at each session? min/hrs

Does the patient have an appropriate size chair?	☐	☐
Does the patient have a pressure redistributing seat cushion?	☐	☐

If yes, please state type of cushion used

SKIN ASSESSMENT

Section A: 1st Assessment / Existing Skin Condition

Please note the condition of skin on admission:

	✓		✓
Normal Skin		History of IAD	
Current PU 1 or above		Vulnerable skin *e.g. blanchable redness that persists, dryness, paper thin, moist, macerated, other*	
History of pervious PU		Moisture lesion present	

If other, please state:

If the patient has an existing wound please indicate the type, location and presence of exudate and odour if any.

Pressure Ulcer Category / Wound Type
(Please tick box)

Location	1	2	3	4	Dehissed Surgical Wound	Abscess	Leg Ulcer	Infected Wound Site
Sacrum								
Trochanter								
Buttocks								
Heel								
Other site								
Exudate								
None								
Low								
Medium								
High								
Odour								
Yes								
No								

Section B: Progress of Existing Wound(s)

WEEK 1 ASSESSMENT

Document **changes** to **existing** wound(s) and provide comments in the box provided:

Is the wound(s):	✓	**Is the level of skin moisture:**	✓
Improving		Improving	
Deteriorating		Deteriorating	
Not changing		Not changing	

Please comment on any changes to the condition of the patient's existing wound, including predisposing factors.

WEEK 2 ASSESSMENT

Document **changes** to **existing** wound(s) and provide comments in the box provided:

Is the wound(s):	✓	**Is the level of skin moisture:**	✓
Improving		Improving	
Deteriorating		Deteriorating	
Not changing		Not changing	

Please comment on any changes to the condition of the patient's existing wound, including predisposing factors.

Section C: New Wound(s)

Please document if the patient develops a **new** wound in this section. Indicate location, grade and size below:

Grade/stage	1	2	3	4	Size (cm²)
Sacrum					
Trochanter					
Buttocks					
Heel					
Other					

If other, please state:

Comments

Please document if the patient develops a **new** wound in this section. Indicate location, grade and size below:

Grade/stage	1	2	3	4	Size (cm²)
Sacrum					
Trochanter					
Buttocks					
Heel					
Other					

If other, please state:

Comments

FINAL EVALUATION

During the course of the evaluation, did the patient's overall skin condition:

	✓
Improve	
Deteriorate	
Remain the same	

Please rate the following:

Patient comfort:

	✓
Very comfortable	
Comfortable	
No view	
Uncomfortable	

Level of moisture control:

	✓
Excellent	
Good	
No view	
Poor	

Patient repositioning:

	✓
Excellent	
Good	
No view	
Poor	

Please enter the final date of the evaluation period: _____ DD / MM / YY

PRODUCT PERFORMANCE & USER FEEDBACK

	Yes ✓	No ✓	N/A
Easy to wipe down during use?			
Was the product easy to install?			
Was the product easy to use?			
Did the product fit the mattress?			

Any additional comments on ease of use and performance?

	Yes ✓	No ✓
Would you use the product again?		

If you have answered no to the question above, please state why in the box provided.

How would you assess the following?

	Excellent	Good	No view	Poor
User instructions				
Product training				
Clinical application				
Company support				
Motor size				
Motor noise level				

Please add any additional comments you may have e.g. progress of tissue damage, comments on product performance or in relation to the patients overall skin condition.

Are there any additional features you would like to see?

Thank you for taking the time to complete this evaluation form.