**Inspection/Observation**
- Colour of the skin (pale/flushed, cyanotic, burned tissue)
- Rash: Note the size, colour, texture and shape of the lesions (e.g.: raised or flat, fluid filled) and the number and distribution (e.g.: sparse, numerous, over limbs etc.), itchy, painful.
- Note which area of the body it covers. Obtain a history of the rash from a parent /carer.
- Non-blanching petechial rash should be reported immediately.
- Bruising/wounds/pressure injuries: Assess any existing wounds and utilise a Wound Care Assessment tab in the EMR flowsheet for ongoing wound assessment and management.
- Examine high risk areas regularly, including bony prominences and equipment sites (masks, plasters, tubes, drains, etc.) for pressure injuries. (Pressure injury prevention and management). Report any irregular bruising.
- Nevi/Moles: Observe for size, any irregular borders, variation in colours. Larger nevi and changing ones should be reviewed by appropriate medical staff.
- Hair: observe the condition of the scalp. Cradle cap is most common in newborns and is identified by thick, crusty scales over the scalp. Observe for lice or ticks

**Palpate:**
- Skin temperature, moisture, turgor, oedema, deformities, hematomas and crepitus
- Hair texture for brittleness, moisture

**Eye**
Inspection of the eye should always be performed carefully and only with a compliant child.

**Inspection/Observation**
- Bilateral symmetry, shape, and placement of eye in relation to the ears.
- Bilateral symmetry, size and shape of the pupils, reactivity to light
- Conjunctiva, and eyelids for inflammation, color and discharge
- Color of sclera
- Iris for upslanting/downslanting of palpebral fissures
- Check visual acuity if child of an appropriate age. If the child is too young to check visual acuity, ascertain whether the child can fix and follow - for toddlers try a toy, for infants try a toy or a light. Assess the requirement for glasses or contacts.
- Visual field
- Presence of tears. (Close eyes in unconscious patient to protect cornea from drying and injury). If unable to close eyes protective eye dressing should be commenced to protect from exposure keratinopathy. (Eye care in PICU guideline)
- Test for red eye reflex. The red reflex test can reveal problems in the cornea, lens and sometimes the vitreous, and is particularly useful as this test can alert us to large lesions in the retina. This test could be done during routine assessment or when parents are concerned about the child's vision or the appearance of her or his eyes. The red reflex is tested by viewing the pupil through an ophthalmoscope from a distance of approximately eighteen inches. A darkened room would be preferred as it is much easier to see the red reflex. To be considered normal, a red reflex should be identical in both eyes. Dark spots in the red reflex, a markedly diminished reflex, the presence of a white reflex, or asymmetry of the reflexes (Bruckner reflex) are all indications for referral to an ophthalmologist.