**Communication Form**

**NEW Skin Condition, Wound(s)/Pressure Ulcers(s) ONLY**

**Identification**

This front section (Identification) is to be completed by the person(s) who observe any NEW skin condition, wound(s)/pressure ulcer(s). The form is completed at the time of the observation, AND forwarded directly to the unit charge nurse for timely inquiry.

Resident: ________________________________________  Room #: ______________________

Date of newly observed skin condition, wound(s)/pressure ulcer(s) : ____________________

Shift (circle):                 Day                  Evening                Night

**Location of NEWLY observed skin condition, wound(s)/pressure ulcer(s):** (circle the location #)

(Observation) What do you see/what does the skin, wound(s)/pressure ulcer(s) look like: (# and circle)

# ___ Reddened area/no break in skin       # ___ Dark area/no break in skin       # ___ Blister
# ___ Scabbed area/no break in skin        # ___ Opened area/break in skin        # ___ Other ________

Form forwarded to: ____________________________________________________

Date: _______________       Time_____________       □ AM    □ PM

Signature ____________________________________________________
**Investigation**

This back section (Investigation and Outcome) is to be completed in its entirety by the charge nurse receiving the form, within the same shift of notification of the **NEW** skin condition, wound(s)/pressure ulcer(s), **AND** forwarded to the Director of Nursing.

Charge Nurse: (print)_____________________________ Inquiry Date: _________ Time____ AM PM

Location(s) of identified **NEW** skin condition, wound(s)/pressure ulcer(s) (anatomical #): __________________________

Skin condition, wound(s)/pressure ulcer(s) appearance/description: __________________________________________

Based on appearance (as applicable) what is the Highest Stage of the wound(s)/pressure ulcer(s) at time of investigation: (circle) I II III IV U DTI Other ______________

Is the resident identified as being at risk for developing pressure ulcer(s)? □ YES □ NO

If yes, are risk factors and applicable plan(s) of care communicated to CNAs/other staffs? □ YES □ NO

If yes, to whom is/was the information communicated: _________________________________________________

If yes, list how the information is/was communicated: _________________________________________________

List how often the information is/was communicated: _________________________________________________

Is/was consistent staff caring for the resident? □ YES Day Evening Night □ NO Day Evening Night

Indicate all areas of care required during the shift identification timeframe:

□ AM/PM care Type _________________ Documented: □ Yes □ No

□ Skin check(s) Documented: □ Yes □ No

□ Toileting/incontinence care Documented: □ Yes □ No

□ Turn and position/re-position Documented: □ Yes □ No

□ Transfer # persons ___________ Documented: □ Yes □ No

□ Activity (bed, wheelchair, geri-chair, mobile) Documented: □ Yes □ No

□ Other: ______________________________ Documented: □ Yes □ No

**Outcome**

Root cause of **New** wound(s)/pressure ulcer(s) __________________________________________________________

__________________________________________________________

Preventative measures implemented to avoid re-occurrence: □ Yes □ No

If yes, type of preventative measure(s): _________________________________________________________________

If no, explain: _______________________________________________________________________________________

Ongoing follow up action/timeframe: _________________________________________________________________

__________________________________________________________

Investigation forwarded to DON □ YES □ NO Date: _____ Time_____ □ AM □ PM

Signature:________________________________________