

Communication Form

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

Identification

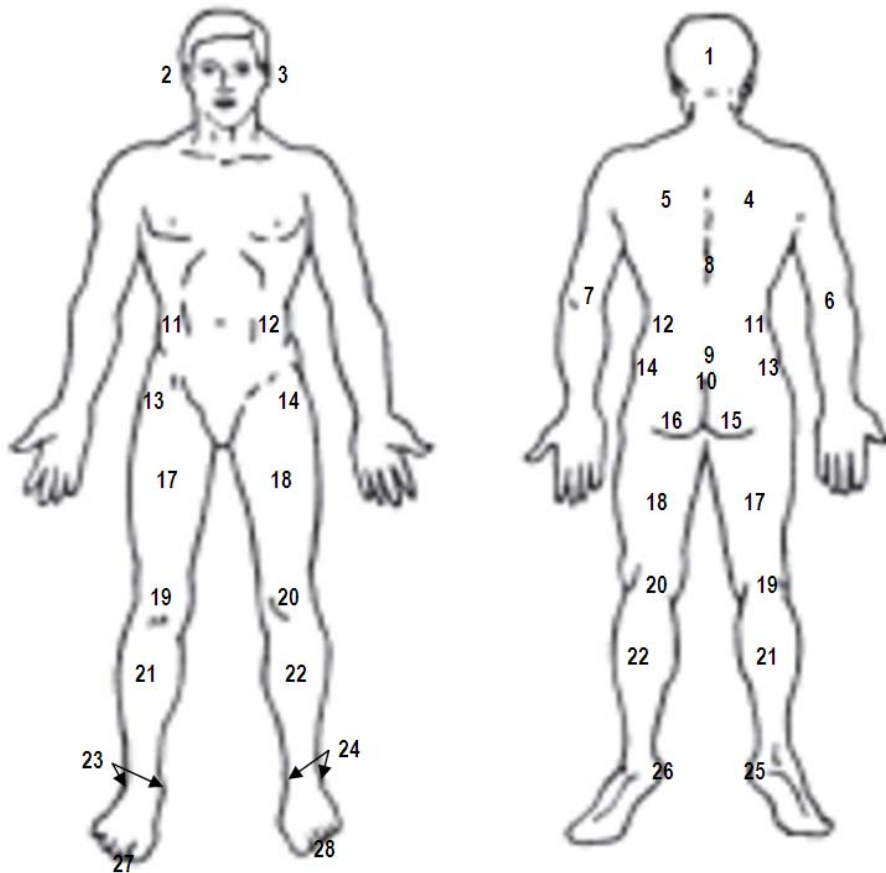
This front section (Identification) is to be completed by the person(s) who observe **any NEW** skin condition, wound(s)/pressure ulcer(s). The form is completed **at the time of the observation**, **AND** forwarded directly to the unit charge nurse for timely inquiry

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 it's 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:

- | | |
|---|--|
| <input type="checkbox"/> AM/PM care Type _____ | Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Skin check(s) | Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Toileting/incontinence care | Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Turn and position/re-position | Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Transfer # persons _____ | Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Activity (bed, wheelchair, geri-chair, mobile) | Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other: _____ | Documented: <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____