Communication Form

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

Identification

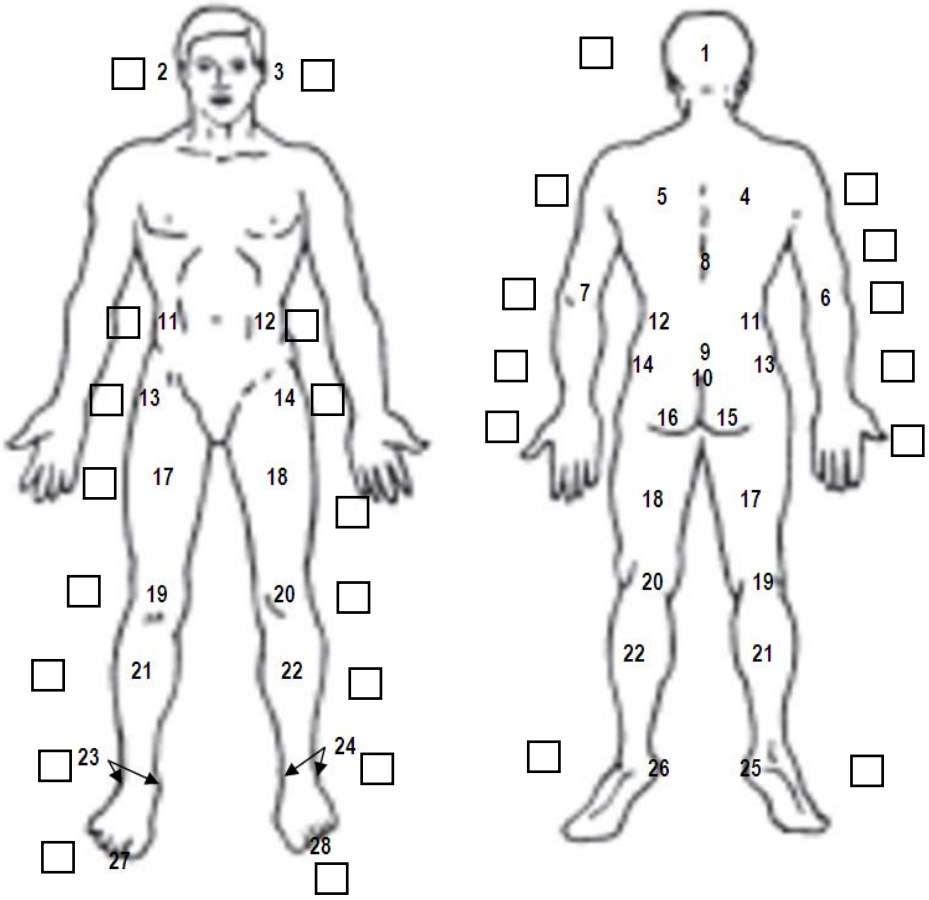
*This front section (Identification) is to be completed by the person(s) who observe **any NEW** skin condition, wound(s)/pressure ulcer(s). The form is completed **at the time of the observation, AND** forwarded directly to the unit charge nurse for timely inquiry*

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:

☐ 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-occurence: ☐ 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:_____

This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 10SOW-NY-AIM7.2-11-16