NOSOCOMIAL INVESTIGATION FORM

Resident Name-_____ Rm#-_____ Physician-_____

Date Identified-			Stage of Wound-			
Wound Location-						
Size	Length-		Width-		Depth-	
Description-						

Determine whether the facility developed an individualized care plan that was consistent with the resident's specific conditions, risks, needs, behaviors, and preferences, and current standards of practice. Determine whether it included measurable objectives timetables, and specific interventions/services to prevent the development of pressure ulcers.

INVESTIGATIVE ELEMENT	Y/N	COMMENTS
Is there documentation that the resident was assessed for the risk of developing a pressure ulcer in a timely, accurate and ongoing manner in accordance with current standards of practice and current facility policy?		Risk Score-_____
Did the individualized care plan address the following…..		
• Appropriate pressure redistribution/relief based upon identified resident needs (repositioning, heel protection, use of a wheelchair/reclining chair and bed/mattress pressure redistribution surfaces)? If so, is there evidence that the staff followed the care plan?		
• Appropriate protocol for the prevention of shearing and friction? If so, is there evidence that the staff followed the protocol?		
• The identification by whom, and how often, the skin is inspected (paying attention to bony prominences)? If so, is there evidence of required skin inspections?		
• The comorbid conditions that may affect risk for pressure ulcers? If any conditions were identified, were appropriate corresponding interventions identified? If so, is there evidence that the interventions have been consistently followed?		
• The risk of skin breakdown posed by fecal/urinary incontinence? If so, is there evidence that the interventions have been consistently followed?		
If the resident has refused or resisted staff interventions to reduce risk for the development of pressure ulcers, does the care plan reflect efforts to seek alternatives to address the needs identified in the assessment?		
Have there been changes in condition that would have justified additional or different interventions? If so, were they addressed?		
Is there evidence that the staff has been monitoring the resident's response to interventions for prevention and has evaluated and revised the care plan based on the resident's response, outcomes, and needs?		
(Nutrition) Is there evidence of an unplanned weight gain, weight loss, or other nutritional concerns?		
(Hydration) Is there evidence that the resident was not consuming sufficient fluid intake to maintain proper hydration and health?		
(Physician Supervision) Is there evidence that the physician assessed and developed a treatment regimen relevant to the prevention a pressure ulcer and responded appropriately to any notice of changes in condition?		
Was the resident's representative (if known) notified of significant changes in the resident's condition in relation to the development of a pressure ulcer?		
For the resident who acquired the new ulcer, was the care plan revised to modify the prevention strategies and to address the presence and treatment of a newly developed pressure ulcer?		
CNAs providing care during the past week (Document assigned CNA names and shifts on the reverse side of this form.)		

Investigation Form Completed By-_____ Date-_____

Date (most recent 1st)	Shift	CNA Name	Comments

Look at the listing of staff that has provided "hands on" care over the past week. Determine degree of repeat assignments and check competencies for items such as "pressure ulcer prevention measures", "timely identification of skin issues", etc.

- Who initially identified the wound?
- Analyze staff involvement with reference to stage of nosocomial pressure wound
- If Stage 1, look at more recent staff assignments for prevention follow-through.
- If beyond Stage 1, look at all staff assignments to analyze when the skin issue should have been identified at an earlier stage.
- If not… why not??

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