Long-Term Care Survey Alert

SKIN CARE MANAGEMENT FORM

Facility _____ Patient name _____ Date_____

Date of admission or readmission _____
Date of last assessment _____
Skin condition upon admission/readmission: (Full skin audit)

Pressure ulcers located (stage): _____
Other wounds, skin problems (location): _____
Bruising: _____

(See attached pictures)

Skin status today: _____

Skin intact _____ Pressure ulcers: location and stage: _____
Other wounds (type/location) _____
_____

Standardized Preventive Care Program

Pressure-reduction surfaces in place. Date ____ Circle all that apply: Bed, chair, wheelchair
Hydration status _____ Average daily fluid intake: _____
Any prior Hx of dehydration noted on MDS? Yes __ No_____ If so, date of MDS____
Diet _____ Weight loss in past week? Yes___ No____Percentage of weight_____ Underweight? Yes___
No___ Obese? Yes___ No___
Diet _____ Supplements? Yes___ No___ Type_____
Continence status and care_____

Comorbidities and Mobility

Diabetes mellitus___Cardiovascular___Peripheral neuropathy_____ Other
_____
Nonambulatory____ Bed bound ____ Wheelchair bound____
Requires help with bed mobility_____ Requires assistance with transfer ____

Specialized Prevention

Turning and repositioning interventions? Yes ___ No ____
Describe _____
Special diet? Type _____ Date of dietary consultation_____
Rehabilitation therapy Yes ____ No_____ (if yes, see attached rehabilitation treatment plan)
Restorative nursing interventions? Yes ___ No____ (If yes, see attached restorative nursing care plan and progress report)
Special skin care regimen? Describe_____

Pressure-relieving mattress for immobile patient? Yes___ No___ Date provided_____

Wound Care

Name of practitioner(s) who diagnosed wound as true pressure ulcer_____ Date _____
Wound care treatment and specialized interventions (see attached care plan)

_____
Change in wound since last assessment? Describe_____

_____

Source: Eli Research