| Person’s Name | Date of Birth | ProviderOne Number |
| --- | --- | --- |
|  |  Developmental Disabilities Administration (DDA) **Skin Observation** **You do not need permission to call 911.** |
| Date of Protocol Creation | POLST DNR/I on file[ ]  Yes [ ]  No | Where is the POLST DNR/I located? | Date Signed |
| When to call healthcare provider: |
|  |
| Call 911 and **START FIRST AID** as trained if:Below are possible signs of infection which could be life threatening.1. The person is not breathing or is blue / gray in color.
2. The person is having difficulties breathing or making abnormal noises while breathing.
3. The person appears ill; and you are concerned about their immediate health and safety.
4. The person has a temperature greater than  or less than .
5. Other:

**After 911 has been notified, follow instructions from the dispatcher. Notify the dispatcher if there is a POLST DNR/I in place.**After calling 911 and stabilizing the person:* Contact your supervisor.
* Document per agency protocol in the person’s chart.
 |
|  |
| **General Signs of Skin Injury** |
| * Changes in the color of skin.
* Changes to the texture of skin.
* Changes to temperature of the skin: cold or warm to touch
* Pain or discomfort to an area of the skin.
* Swelling or open areas of the skin.
* Drainage from an area of the skin.
 |
| **Common areas for Pressure Injuries** |
|  |  |
| **Pressure Injury Stages** |
| Diagram  Description automatically generated**\*SDTO – Deep Tissue Pressure Injury** |
| **Get to Know Me and My Skin** |
| I need the following things to keep my skin healthy:I need the following assistance with position change: [ ]  Independent [ ]  Some Assistance [ ]  Total AssistanceComments: I have a prescribed positioning schedule in place: [ ]  Yes [ ]  NoComments: I need the following assistance with toileting: [ ]  Independent [ ]  Some Assistance [ ]  Total AssistanceComments: I use the following medications / treatments **to help with my skin’s integrity** (per MAR):[ ]  None |
| **Medication Name** | **Medication Dose** | **Medication Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
| I use the following medications / treatments as needed (PRN) **to help with my skin’s integrity** (per MAR):[ ]  None |
| **Medication Name** | **Medication Dose** | **Medication Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
| I have current pressure injuries: [ ]  Yes [ ]  NoLocation of pressure injuries: I have a history of pressure injuries: [ ]  Yes [ ]  NoLocations of previous pressure injuries: I have a wound care program: [ ]  Yes [ ]  NoIf yes, describe program: I have a wound care treatment provider: [ ]  Yes [ ]  NoIf yes, wound care treatment provider name / contact / schedule: |
| Wound Care Provider’s Name | Wound Care Provider’s Contact Information |
| Wound Care Provider’s Schedule |
| I have a Nurse Delegator who trains staff on medication administration: [ ]  Yes [ ]  No |
| Delegator’s Name | Delegator’s Phone Number |
| Notify my Nurse Delegator when I (follow Nurse Delegation Instructions and Task form):  |
| **How to Prevent a Pressure Injury** |
| * Complete daily skin inspections with person consent and privacy.
* Get recommended amount of fluids.
* Eat a well-balanced diet of fruits, vegetables, carbohydrates, and proteins.
* Good skin hygiene: clean skin immediately after becoming soiled, use a mild soap and soft cloth, hydrate the skin with lotion and barrier creams, per physicians’ orders.
* Change positions at least every two hours or as prescribed.
* Other:
 |
| Additional Information |
| Plan Completed by: | Date Plan Completed |
| Health Care Provider’s Signature | Date Signed |

|  |  |
| --- | --- |
|  |  |

|  |  |
| --- | --- |
| Health Care Provider’s Name | Phone |
| **Date of last review (enter signature and date):** |
|  |  |  |
|  |  |  |
|  |  |  |