| 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 Assistance  Comments:  I have a prescribed positioning schedule in place:  Yes  No  Comments:  I need the following assistance with toileting:  Independent  Some Assistance  Total Assistance  Comments:  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  No  Location of pressure injuries:  I have a history of pressure injuries:  Yes  No  Locations of previous pressure injuries:  I have a wound care program:  Yes  No  If yes, describe program:  I have a wound care treatment provider:  Yes  No  If 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):** | | | |
|  |  |  | |
|  |  |  | |
|  |  |  | |