

## Health Care Aide Skin Observation Form

Addressograph Label  
 Client Label  
 DOB mm/dd/yyyy  
 PHIN/MHSC#  
 HRN

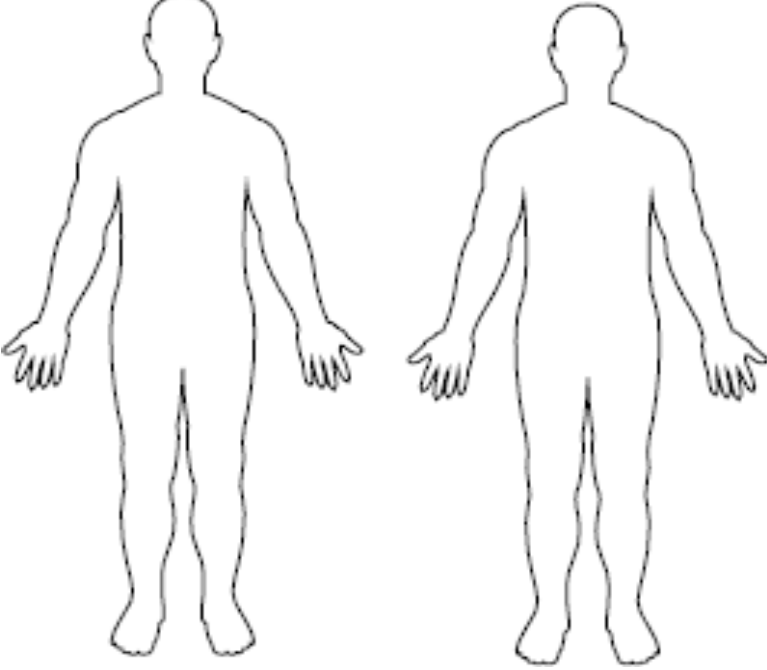
This form (For use in Long Term Care, Acute Care, and Transitional Care) is completed by a Health Care Aide (HCA) weekly on all clients with a Braden scale of 18 or less & anytime a problem is observed

- If no problem observed, complete Section A
- If any problems observed, complete Section B and give form to nurse
- Nurse completes Section C once received by the HCA

**A. If NO concerns observed HCA to complete below.** One form is used several times if no problems are observed.

Date	Name HCA making observation	Date	Name HCA making observation	Date	Name HCA making observation

**B. If there are skin concerns observed, complete below and give form to nurse.** A new form is initiated with next observation.

<p><b>Skin Observation Findings</b>          Use a number as per legend to mark site and type of finding on body diagram below:</p> <div style="text-align: center;">  </div>	<p><b>Legend:</b>          1. Bruise    2. Skin Tear    3. Rash    4. Red Area          5. Scab    6. Wound    7. Scratch          8. Other: _____</p> <hr/> <p><b>Prevention Strategies in Use</b>  <b>YES NO</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Offloading device in use: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Properly Inflated &amp; in good condition _____</p> <p><input type="checkbox"/> <input type="checkbox"/> SCHIPP protocol in use          (e.g.; slider, transfer belt, logos in place, etc.)</p> <p><input type="checkbox"/> <input type="checkbox"/> Incontinent product: _____</p> <p>Other: _____</p> <hr/> <p><b>Interventions in Use</b>  <b>YES NO</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Soaker PAD on bed          If yes, why? _____</p> <p>Name/Signature of HCA completing form: _____</p> <p>Date completed: _____</p> <p><b>Reported to:</b> _____  <i>(Name of Nurse)</i></p>
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**C. Nurse to review section B and complete Section C as appropriate**

<p><b>Skin Impairment Identified:</b></p> <p><input type="checkbox"/> Nursing assessment done      <input type="checkbox"/> Care Plan Developed</p> <p><input type="checkbox"/> Skin Care provided              <input type="checkbox"/> Kardex/Care Plan Updated</p> <p><input type="checkbox"/> Wound Care Provided           <input type="checkbox"/> Documented in IPN</p>	<p><b>If Related to Pressure:</b></p> <p><input type="checkbox"/> Injury staged (if appropriate)      <input type="checkbox"/> Braden Scale completed</p> <p><input type="checkbox"/> Kardex/Care Plan Updated           <input type="checkbox"/> Intervention Checklist completed</p> <p><input type="checkbox"/> Documented in IPN                      <input type="checkbox"/> Other: _____</p>
<p>Name/Signature of Nurse completing: _____ Date completed: _____</p>	