Home Care Health Care Aide Skin Observation Form

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

Date Initial Assessment: _____ ** Return to Resource Coordinator (RC) 1 month after initial assessment is reported
This form (For use in Home Care) is completed by a Health Care Aide (HCA) weekly on all home care clients (as appropriate) with a Braden scale of 18 or less & anytime a problem is observed

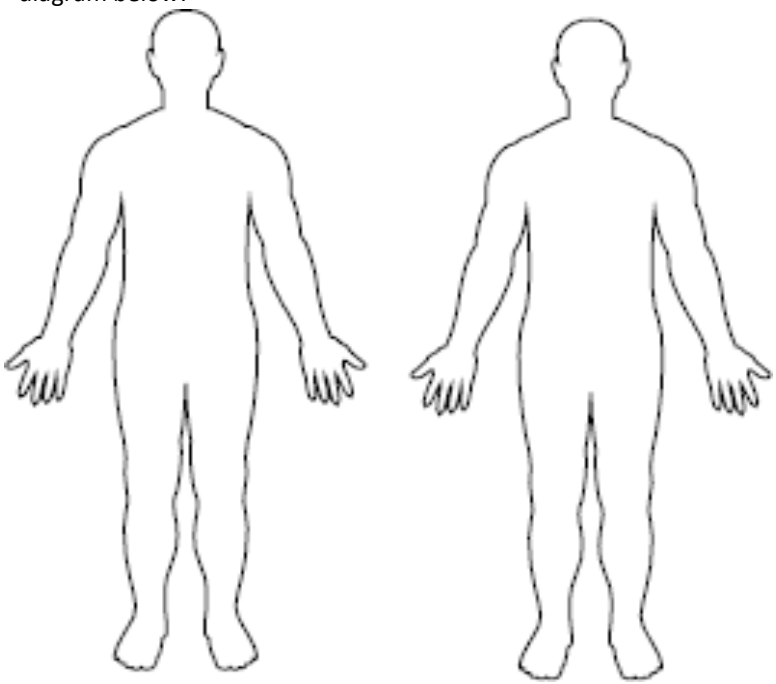
- If no problem observed, complete Section A
- If any problems observed, complete Section B and give form to nurse
- Nurse completes Section C once received by the HCA

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.

Skin Observation Findings
Use a number as per legend to mark site and type of finding on body diagram below:



Legend:
1. Bruise 2. Skin Tear 3. Rash 4. Red Area
5. Scab 6. Wound 7. Scratch
8. Other: _____

Prevention Strategies in Use

YES	NO	
☐	☐	Offloading device in use: _____
☐	☐	Properly Inflated & in good condition _____
☐	☐	SCHIPP protocol in use (e.g.; slider, transfer belt, logos in place, etc.)
☐	☐	Incontinent product: _____

Other: _____

Interventions in Use

YES	NO	
☐	☐	Soaker PAD on bed

If yes, why? _____

Name/Signature of HCA completing form: _____

Date completed: _____

Reported to: _____
(Name of Nurse)

C. Nurse to complete area(s) below as appropriate and share information with Case Coordinator (CC) **** Note- can also be completed by CC when client/family requested to follow up***

Skin Impairment Identified:
☐ Nursing assessment done ☐ Care Plan Developed
☐ Skin Care provided ☐ Kardex/Care Plan Updated
☐ Wound Care Provided ☐ Documented in IPN

If Related to Pressure:
☐ Injury staged (if appropriate) ☐ Braden Scale completed
☐ Kardex/Care Plan Updated ☐ Intervention Checklist completed
☐ Documented in IPN ☐ Other:

Name/Signature of Nurse completing: _____ Date completed: _____