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|---------------|---------------|--------------------|
| 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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.

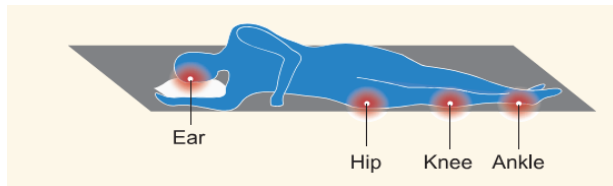
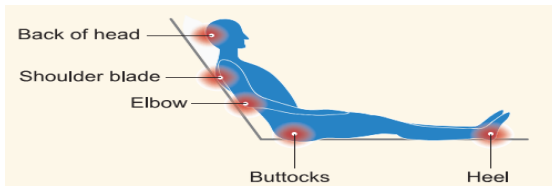
After calling 911 and stabilizing the person:

- Contact your supervisor.
- Document per agency protocol in the person's chart.

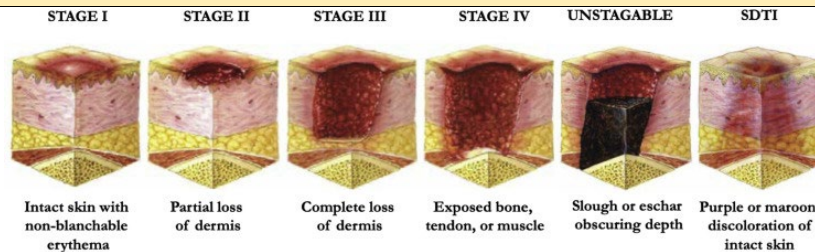
General Signs of Skin Injury

- 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



*SDTI – Deep Tissue Pressure Injury

Do not delay creation of a protocol while awaiting medical provider approval.

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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): |
|--|

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| How to Prevent a Pressure Injury | | |
| <ul style="list-style-type: none"> • 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): | | |
| | | |
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| | | |

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