

Purpose

This form is completed by the assigned RN following a Support Worker escalation. Your assessment determines the clinical care plan, communicates risk to the care team, and triggers the Care Partner review. All fields marked * are required.

Support Worker Report Summary (pre-populated from system)

Case ID	Client Name	Visit Date	Reported By
Support Worker Concern Description			
Concern Location		Wound Type Reported	

1 Assessment Details

RN Full Name *	Assessment Date *	Assessment Time *

Assessment Type *

☐ **Virtual**
Phone / video call

☐ **In Person**
On-site assessment

2 Braden Score

Q7 — Braden Score ____ / 23 (lower scores = higher risk)	Q8 — Date Score Completed

Q9 — Risk Category

Low
Score 19–23

Moderate
Score 13–18

High
Score ≤ 12

3 Clinical Assessment

Summary of concern * (will be visible to care team and used in reporting)

Clinical observations * (wound characteristics, tissue type, exudate, odour, surrounding skin, peri-wound)

Wound dimensions (if applicable — L × W × D)

Pressure injury stage (if applicable)

- ☐ Stage 1 — Non-blanchable erythema
- ☐ Stage 2 — Partial thickness skin loss
- ☐ Stage 3 — Full thickness skin loss
- ☐ Stage 4 — Full thickness tissue loss
- ☐ Unstageable
- ☐ Deep Tissue Injury (DTI)
- ☐ Not a pressure injury

Exudate amount

☐ None ☐ Low ☐ Moderate ☐ High

Surrounding skin (e.g. macerated, erythematous)

Pain assessment (pain score and description e.g. 4/10, aching at rest)

4 Severity & Risk Assessment

Severity / Risk Level *

☒ **Low**

Monitoring sufficient

☐ **Moderate**

Regular review needed

☐ **High**

Urgent intervention required

☐ **Critical**

Immediate escalation

Is further escalation required?

☐ Yes ☐ No

If yes — escalation details (who needs to be notified, what urgent action is required)

5 Action Plan & Recommendations

Action taken * (select all that apply)

- ☐ Dressing applied / changed
- ☐ Pressure relief commenced
- ☐ Repositioning advised
- ☐ GP / specialist informed
- ☐ Skin integrity care plan updated
- ☐ Monitoring only
- ☐ Other: _____

Recommendations for care team * (dressing changes, monitoring frequency, equipment needs, referrals)

Recommended follow-up frequency

- ☐ Daily ☐ Every 2 days ☐ Twice weekly ☐ Weekly ☐ Fortnightly ☐ As needed

6 Feedback Loop

Q19 — Feedback loop complete?

- ☐ Yes ☐ No

Q20 — Was the concern appropriately identified by the support worker?

- ☐ Yes ☐ No

7 Clinician Declaration

I confirm that the clinical information recorded in this assessment is accurate to the best of my knowledge and has been completed in accordance with Glow Health Care Australia's clinical protocols.

RN Signature

AHPRA Registration Number

Date
