

Purpose of this Form
The Care Partner completes this review after receiving the RN's clinical assessment (Form 2). This form coordinates care plan updates, service adjustments, and ensures continuity of care for the client's skin integrity needs.

1

Review Details

Q1. Care Partner Name

Q2. Review Date & Time

Client Name

Client ID / Reference

RN Who Completed Assessment (Form 2 reference)

Date of RN Assessment Received

Q3. RN Assessment Summary (brief summary of findings from Form 2)

Q4. Severity Level as Assessed by RN

☐ Low

☐ Moderate

☐ High

☐ Critical

2

Care Coordination

Q5. Actions Taken Following RN Assessment

☐ Reviewed RN clinical assessment (Form 2) in full

☐ Discussed findings with client and/or family / representative

☐ Coordinated with support workers on updated care requirements

☐ Arranged or requested specialist referral (e.g. wound care nurse, GP, allied health)

☐ Escalated to emergency services or hospital (critical severity only)

☐ Other — specify below

Q6. Was the client or their representative communicated with regarding the assessment outcome?

☐ Yes

☐ No — reason:

Q7. Were any external referrals or service changes arranged? If yes, provide details below.

☐ Yes

☐ No

3 Care Plan Update

Q8. Is a care plan update required based on the RN assessment?

☐ Yes ☐ No — existing plan remains appropriate ☐ Under review — pending specialist input

Q9. If yes, describe care plan changes required or made

Q10. Has the care plan been updated?

☐ Yes ☐ No — pending

If yes — Date Updated

Q11. New or adjusted care tasks for support workers

4 Continuity of Care

Q12. Is a skin integrity care plan now in place for this client?

☐ Yes — active and documented ☐ In progress ☐ Not required at this time

Q13. Has follow-up care been allocated?

☐ Yes ☐ No

Q14. Follow-up care details (who, what, when)

Q15. Next review scheduled

Date

By whom

Review type

☐ RN ☐ CP ☐ SW

5 Communication & Feedback Loop

Q16. Has feedback been provided to the assessing RN?

☐ Yes ☐ Not required ☐ Pending

If yes, feedback provided:

Q17. Has feedback been provided to the support worker(s) involved?

☐ Yes ☐ Not required ☐ Pending

If yes, feedback / instructions provided:

Q18. Have further actions been communicated to all relevant team members?

☐ Yes — all team members informed ☐ Partially — some pending ☐ No — reason:

Q19. Additional notes or observations

6 Care Partner Declaration

By signing below, I declare that:

- ☐ I have reviewed the RN clinical assessment and understand the findings
- ☐ I have taken appropriate action to coordinate care in response to this assessment
- ☐ All information recorded in this form is accurate and complete to the best of my knowledge
- ☐ I understand this document forms part of the client's permanent care record

Care Partner Signature

Print Name

Date