Geri-IDT

GERIATRIC-INJURY DOCUMENTATION TOOL
TO DOCUMENT INJURY-RELATED PHYSICAL FINDINGS FOR GERIATRIC PATIENTS

This tool will assist with documentation when an older person has an injury. When one injury is noted, a head-to-toe exam to look for other injuries is warranted. Photograph physical findings if possible. In a case of suspected sexual abuse, follow the appropriate protocols.

For each injury, document:

- Reported mechanism of injury(ies)
- How did it happen/how did the injury(ies) occur?
- Was there pain at the time of the injury(ies) and is there pain now?
- Who is reporting the history? Who else is present while report is given?
- Tenderness to palpation and how it is expressed (e.g. verbal, grimacing, moaning, withdrawal, etc.)
- Precise Location
- Size

Document the following characteristics:

INJURY	CHARACTERISTICS TO DOCUMENT
Abrasion	shape, bleeding, cleanliness, dressings, presence of foreign particles
Bite mark	depth, cleanliness, signs of infection
Bruise	shape, color(s), size, swelling, pattern, induration
Burn	burn degree(s), signs of infection, total body surface area
Deformity	bone(s) fractured, whether open or comminuted, healing status, joint(s) dislocated
Laceration	depth, bleeding, cleanliness, linearity/jaggedness, presence of foreign particles, signs of infection
Petechia	location, size, color
Skin Tear	bleeding, dressings, presence of foreign particles, signs of infection
Swelling	size

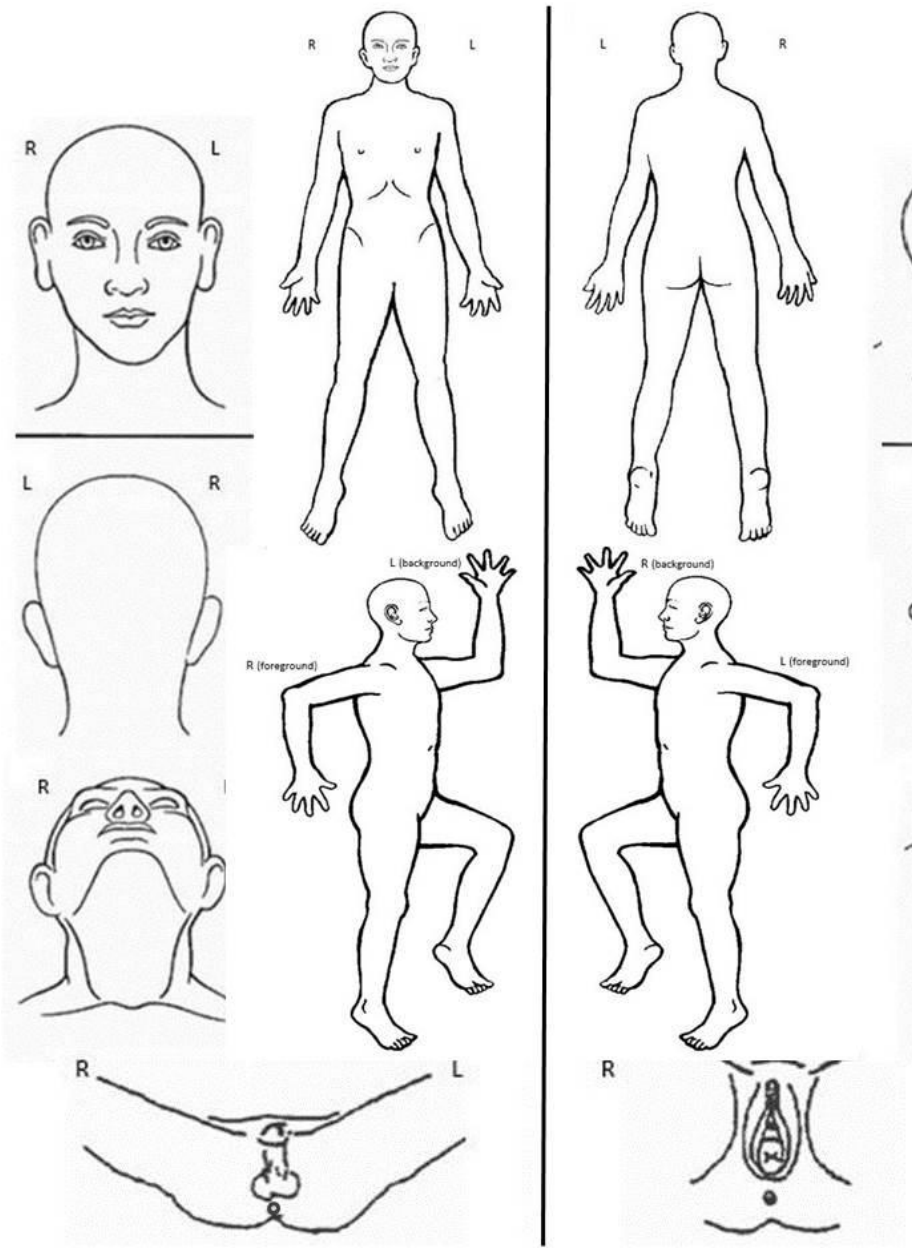
Document initial physical appearance (including hygiene) on presentation and indications of alcohol or substance abuse.

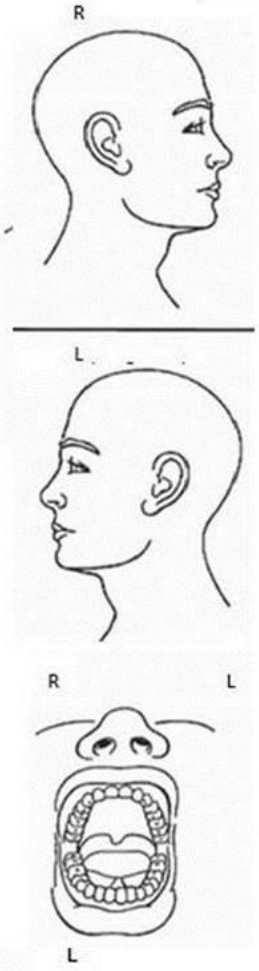
PRESSURE/WOUND	CHARACTERISTICS TO DOCUMENT
Pressure sore/injury	depth/stage[1], size, odor, exudate, evidence of wound care, dressing, signs of infection

[1]National Pressure Ulcer Advisory Panel stages of pressure injury (2016):

Stage I Non-blanchable erythema of intact skin
Stage II Partial-thickness skin loss with exposed dermis
Stage III Full-thickness skin loss
Stage IV Full-thickness skin and tissue loss
Unstageable: Obscured full-thickness skin and tissue loss such as eschar
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration

Conduct a complete head-to-toe physical examination and describe in detail all physical findings on the patient, even those that you do not consider clinically significant or related to their presenting complaint. **Please note all areas where <u>pain</u> or <u>tenderness</u> is present, even if there is no visible evidence of injury.**





Please number each finding indicated on the body diagram and describe the physical characteristics:

(e.g. 1=5cm jagged laceration, with redness and swelling, soiled dressing, moderate odor)

Finding 1:

Finding 2:

Finding 3:

Finding 4:

Finding 5:

Finding 6:

Finding 7:

Finding 8:

Finding 9:

Finding 10:

Patient's Name: _____

MRN: _____ DOB: _____/_____/_____

Clinician's name (print): _____

Signature: _____ Date: _____/_____/_____