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| HealthCert | **Notification of a pressure injury** |  |

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| **1. Premises** |
| Legal entity name |
| Enter legal entity name. |
| Premises name |
| Enter premises name. |
| District |
| Enter the district the premises is in. |

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| **2. Pressure injury details** | |
| Stage of pressure injury | |
| Choose an item. | |
| Location of pressure injury | |
| Describe the pressure injury site. | |
| If the resident has more than one pressure injury, provide details of all other pressure injuries | |
| Enter details of any other pressure injuries. | |
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| Was the pressure injury acquired at the facility? | Choose an item. |
| If acquired at the facility, when was the pressure injury identified? | |
| Enter the date the pressure injury was identified. | |
| If not acquired at the facility, where was the pressure injury acquired? | |
| Choose an item. | |
|  |  |
| Has a wound nurse specialist assessed the pressure injury? | Choose an item. |
| If no, provide comments on why not | |
| Comment. | |
| If yes, provide date | |
| Enter the date the pressure injury was assessed. | |
|  |  |
| Is a wound specialist reassessment scheduled? | Choose an item. |
| If no, provide comments on why not | |
| Comment. | |
| Itemise the fit for purpose equipment at the facility that will meet the care needs of this resident | |
| Itemise equipment, for example, hoist, alternating air mattresses, pressure relieving mattresses, pressure relieving cushions, cloud chairs, limb protectors, hoists, slippery sams, turning charts. | |
| Any other comments? | |
| Comment on care being provided and actions taken to reduce future risk of deterioration. | |

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| **3. Resident’s details** | | | | | | |
| Title |  | First name(s) | | |  | Last name |
| Choose an item. |  | Enter first name(s). | | |  | Enter last name. |
| Date of birth | | |  | NHI number |  |  |
| Enter date of birth. | | |  | Enter NHI number. |  |  |

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| **4. Declaration to be completed by a Registered Nurse** |

I declare that the information provided is true and correct.

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| Name |  | Date |
| Enter your name. |  | Enter date. |
| Designation | | |
| Enter your designation. | | |
| Phone number | | |
| Enter your phone number. | | |

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| **5. Submitting form** |

Please email the completed form to certification@health.govt.nz.

If you have any questions, please contact HealthCERT on 0800 113 813.

If you hold a contract with Te Whatu Ora, you should also send a copy of this form to your Te Whatu Ora Portfolio Manager.

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| **6. Further action** |

Please email certification@health.govt.nz if:

* this pressure injury deteriorates to the point where the named resident requires hospital admission for treatment of the injury
* the pressure injury is a contributing factor to an untimely death
* the reported pressure injury increases in severity.