Head to Toe Suspected Infection Investigation Tool

Resident:_____ **Date:**_____ **Staff Initials:**_____

What is different or concerning about the resident today?

Check the box next to any area where you have observed a change or a concern, and document that concern in the space provided.

❑ Head, Ears, Eyes, Nose, Mouth, and Throat_____

❑ Breathing/Cough_____

❑ Oral Intake (Eating/Drinking)_____

❑ Skin_____

❑ Orientation/Mood/Energy_____

❑ Lines/Catheters/Tubes_____

❑ Mobility_____

❑ Voiding_____

❑ Other_____

_____

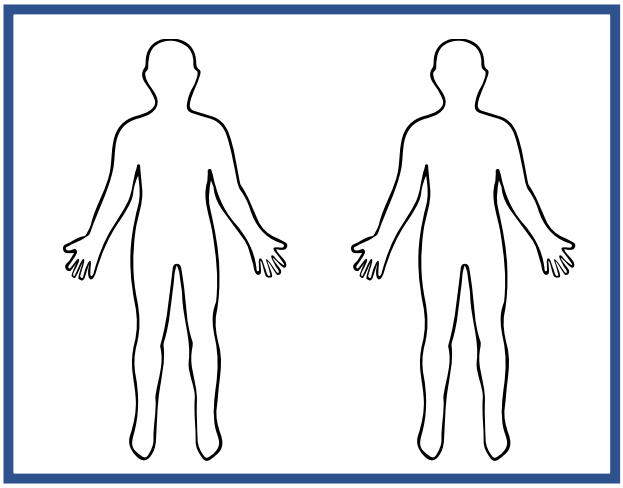
Document Vitals:

Vital Signs	**Time:**
Blood Pressure	mmHg
Pulse	beats per min
Respiratory Rate	breaths per min
Temperature	ºF
Pulse Oximetry	% ❑ On Room Air ❑ On O_2 (_____L)

Any complaints or nonverbal expressions of pain?

❑ No

❑ Yes, circle where the pain is below.



Front **Back**

Do any of these questions apply to the resident?

Check the box if the question relates to the resident.

GENERAL:

- ❑ Has there been a change in energy, mood, or orientation?
- ❑ Is the resident less active than usual?
- ❑ Any change in appetite, food, or fluid intake?
- ❑ Any complaints of pain or non-verbal expressions of pain (e.g., guarding, wincing, groaning)?

MOUTH:

- ❑ Any difficulty chewing, refusal to eat, or only chewing on one side of the mouth?
- ❑ Do the gums, lips, cheeks, or tongue seem very dry or cracked?
- ❑ Any redness or bleeding in the mouth or gums?
- ❑ Any concern for fit of dentures or dental appliances?
- ❑ Are there food particles in the mouth after eating that cannot be easily removed?
- ❑ Any white patches on the tongue and/or cheeks?
- ❑ Any bad breath?

SKIN:

- ❑ Any redness, bruising, bleeding, or texture changes to the skin?
- ❑ Are toenails or fingernails discolored? Is there any dirt stuck underneath?
- ❑ Are there any new cuts, wounds, or scrapes?
- ❑ Are there any areas that are warm or hot to touch?
- ❑ Any drainage or odor changes to the skin?
- ❑ Is the skin flaky or crusted?

URINARY TRACT:

- ❑ Any change in urine color, odor, or clarity? Can you see any blood in the urine?
- ❑ Any change in the amount of urine (e.g., new incontinence, frequent urination, not producing urine)?
- ❑ Any pain or burning when urinating? Any pain above the pubic area or in the lower back?
- ❑ Any concerns for dehydration?

Do any of these special considerations apply to the resident?

Check off the box or provide additional information in the “other” box below.

- ❑ Diabetic
- ❑ Urinary Catheter
- ❑ Cognitive Impairment/ Dementia
- ❑ Post-Surgery
- ❑ Wounds
- ❑ Difficulty Swallowing
- ❑ Other:_____

Additional Notes:

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Once you have completed this form, give it to the licensed nurse.